Transatlantic Practice Exchange 2014

Reports from 10 frontline professionals on an international exchange of knowledge and practice.
## Contents

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>About the Transatlantic Practice Exchange 2014</td>
<td>3</td>
</tr>
<tr>
<td>Opening thoughts</td>
<td>4</td>
</tr>
<tr>
<td><strong>English participants</strong></td>
<td></td>
</tr>
<tr>
<td>Trauma-informed care</td>
<td>6</td>
</tr>
<tr>
<td>Housing First for people with dual diagnosis</td>
<td>13</td>
</tr>
<tr>
<td>Permanent supportive housing</td>
<td>19</td>
</tr>
<tr>
<td>Stabilisation: helping people come home for good</td>
<td>26</td>
</tr>
<tr>
<td>Permanent supportive housing for people over 50</td>
<td>33</td>
</tr>
<tr>
<td><strong>US participants</strong></td>
<td></td>
</tr>
<tr>
<td>Hospital Discharge Strategies</td>
<td>39</td>
</tr>
<tr>
<td>Chronically Excluded Adults: the MEAM Approach</td>
<td>44</td>
</tr>
<tr>
<td>No Second Night Out</td>
<td>49</td>
</tr>
<tr>
<td>Psychologically Informed Environments</td>
<td>55</td>
</tr>
<tr>
<td>Youth Homelessness: Nightstops and Reconnect</td>
<td>61</td>
</tr>
</tbody>
</table>
About the Exchange

The Transatlantic Practice Exchange was funded by the Oak Foundation and delivered by Homeless Link in England and the National Alliance to End Homelessness in the US.

Exchanges took place between May and July 2014, with participants spending up to two weeks on placement with their hosts and other local organisations.

Homeless Link and the National Alliance to End Homelessness would like to thank all the hosts and participants for their commitment and enthusiasm throughout the project.

Participant blogs

Many participants blogged and took to social media to share their experiences of the Exchange.

You can find all those articles and comments online at http://bit.ly/homelesslearning.

Further information

For further information on UK participants and hosts please contact Tasmin Maitland, Homeless Link’s Head of Innovation and Good Practice.

E tasmin.maitland@homelesslink.org.uk
T +44 20 7840 4451

For further information on US participants and hosts, please contact Julie Klein, the National Alliance to End Homelessness’ Assistant to the President / Policy Outreach Associate.

E jklein@naeh.org
T +1 202 942 8281
From England

The nature of public services is changing, and the perception of and the public value that they create is being challenged.

Welfare reform, funding changes, increased localisation and changing demographics have produced significant challenges to the way that things are done.

Often seen as threats to the way that we provide services, such circumstances also provide opportunities to rethink how, as homelessness services, we create public value for the people that we serve and the wider population.

The Transatlantic Practice Exchange was designed against this backdrop to provide a space for new thinking about the ways that we deliver services.

This year, five front line staff from England travelled to the USA to learn about different ways of delivering services to particular groups. The structure of the placements enabled participants to develop an understanding of the context in which these services operate, giving them a unique insight into how things can be done differently - and also why they are done differently.

You'll see two overarching themes in the reports from the UK participants.

The need for therapeutic interventions

A lot of emphasis has been put on the role of homeless services in providing therapeutic interventions - in particular the need to understand trauma as a support need for people who become homeless, and to work with staff to understand how to offer less structure, holistic therapeutic services that will enable them to access long term mainstream support.

Challenging the short term nature of support in the UK

Traditionally, homelessness and supported housing solutions have been offered as transitional services. There is increasing awareness that this creates, for some clients a revolving door at the point where support is withdrawn. Three of the English participants show how working long term with people who have complex needs can lead to better outcomes and reduce the cost of repeated use of expensive crisis services. With an aging population, an increasing proportion of the UK’s homeless population are over 55. They exist in the margins between 'mainstream homelessness services' and elderly care services. Again the Exchange showed that tailored and permanent accommodation for this group is a cost effective model.

These reports are written by the exchange participants and include key findings as well as personal insights. All offer fresh thinking about how we tackle homelessness in the current context.

Mark McPherson
Director of Strategy, Partnership and Innovation
Homeless Link

From the US

The US has a serious homelessness problem and a sizable system to address it. Since homelessness first emerged here in the 1980s, we have improved our approaches and developed many effective practices: permanent supportive housing, Housing First, rapid re-housing, and Critical Time Intervention are a few. We have also improved our systems by taking a much more data-driven, outcome-oriented approach. In recent years, we have reduced the number of people who experience homelessness, and ended homelessness for millions of people. Despite these improvements, significant gaps in our knowledge remain, and there is much more that we need to learn or discover.

One important way for us to learn new things – and possibly share a few of our own successes – is through exchange with other nations that face similar problems. This is why we were so excited when the Oak Foundation decided to support Homeless Link and the National Alliance to End Homelessness to implement an exchange, allowing practitioners from each country to visit the other for an intensive look at interventions that were not being implemented at home.

The exchange was extraordinarily productive, both to the participants and to the broader audience with whom they shared their thoughts through conferences, reports, and their work. Some of the observations that emerged in the reports - and there were many - include:

- The advantages of a more comprehensive set of social benefits in the UK. With income, housing and health care support on the table, intervention models can be designed more comprehensively, whereas in the US programs often have to piece together housing, services
and income on a case-by-case basis. Team approaches and other methods of service integration can also be easier. And professionalized services are more often available. On the other hand, innovating outside of the set and funded program models can be a challenge.

- A greater focus on youth homelessness in the UK than is the case in the US. As above, professionalized services across a spectrum of housing, employment, and education are available, and family intervention and support are more systematically available and applied. At the same time, there are youth who fall between the cracks in the system. Also, the network of support is fraying as social benefits are being reduced.

This was a valuable project, for the participants and for anyone interested in ending homelessness. Our gratitude goes to the Oak Foundation and our partners at Homeless Link for making it happen. And our very special thanks to the US and UK practitioners whose commitment and curiosity led them to take the journey -- and the generous and talented organizations that hosted them.

Nan Roman
President and CEO
National Alliance to End Homelessness
Jo Prestidge
Trauma-informed care

Host: CUCS (Center for Urban Community Services)
Location: New York
In June 2014, I took part in the Transatlantic Practice Exchange, to explore how a homelessness organisation in New York is using Trauma-Informed Care to engage chronically homeless people with complex needs.

Like many working in frontline homelessness services in the UK, I do not have a professional qualification that has taught me how to deal with the complex individuals our sector serves. In 2011, having worked in frontline services for some years, I moved to work in an innovative project which provides a personalised budget and intensive 1:1 support to long term and entrenched rough sleepers across London. This flexible and client-led service has seen a number of these individuals move away from the street into accommodation. However, despite my acquired skills and experience there are still some people who have seemed ‘unreachable’. I have also observed that many of my clients go into crisis once they do leave the street. All of this, at times, left me feeling helpless and frustrated and wondering if there might in fact be a lot more I could and should do in my role.

With already limited mental health and psychological service provision for homeless people in the UK, and ongoing funding cuts to the public sector, the level of resource needed to engage assertively with a population who are unable or unwilling to access services is non-existent. With the personal drive to improve my own knowledge and skills at engaging people who are considered ‘hard to engage’, I started to consider how as a sector we may in fact have a much larger role to play in providing therapeutic support to our clients. With increased focus on Psychologically Informed Environments, I was keen to explore whether there was anything we might learn from the US to integrate into this model.

I had three clear areas of learning that I wanted to explore:

1. Trauma and how it affects people who are homeless
2. How staff are using a trauma-informed approach to improve their practice
3. How I could share my findings with staff working on the frontline in the UK.

Homelessness in New York City

Unlike the UK, which has clear laws around housing and homelessness, New York City has little legislation relating to people in housing need. However it is the only city which has a mandate to provide shelter to everyone who becomes homeless.

Since 2002, the number of people using the municipal shelters has increased by 75%, with the current numbers on any given night estimated at 55,000, including 23,000 children. The recession, rising unemployment and increasingly unaffordable rents are the reason why many more families are relying on the shelter system.

The last count of those sleeping on New York’s streets and subways found more than 3,000 people - approximately six times as many as in London. Studies have shown that the needs of New York’s single homeless people are quite different to those of families, with significantly higher rates of mental illness, substance misuse and other severe health needs.

To understand the reason for this, we must consider wider social issues of the last few decades.

In the 1950s, New York City began to close public mental health institutions in a process known as deinstitutionalisation. The discharge of more than 85,000 people from hospital into the community, between 1955 and 1994, coincided with advancements in anti-psychotic medication. The aim was to provide care in less restrictive settings. Unfortunately the level of care needed to support these individuals in the community was lacking, and over the decades many of them became homeless.

From the mid 1980s, America also saw an influx of crack cocaine use, particularly in inner cities like New York. It was cheap to buy and the numbers using it rocketed. Between 1984 and 1990, there was an increase in violent crime, homicide and the number of children being removed from their families into foster care.

Not only were individuals with untreated mental illness and/or problematic crack use becoming homeless, subsequent dysfunction seen within families and communities has also lead to intergenerational traumatisation resulting in a steady flow of individuals with complex needs becoming homeless.

Center for Urban Community Services (CUCS)

Columbia University Community Services was founded in the late 1970s at Columbia University’s School of Social Work. Tony Hannigan, the Executive Director of CUCS, was hired by the university to develop an interdisciplinary program, focused on the needs of single, disenfranchised low-income people to provide a basis for developing a curriculum about this underserved population. He created field work opportunities for students and faculty by opening a day centre and working with residents in local budget hotels. CUCS went on to become one of the first and largest providers of supported accommodation in the US in addition to being the first
organisation to take mental health services into the municipal shelter system.

As levels of homelessness continued to rise in the 1980s, CUCS developed more services to meet the need, becoming an independent organisation and changing its name to The Center for Urban Community Services in 1993.

Today it provides 30 different programmes to homeless individuals and families across NYC. These range from street outreach to transitional and permanent housing, employing over 400 staff. CUCS uses evidence-based practices in their service provision and are leaders in the use of best practice, providing training and assistance to other organisations across the United States.

CUCS has a subsidiary company, Janian Medical Care, which was established in 2011 to continue the work of a group of psychiatrists who were providing psychiatric outreach to people experiencing homelessness across NYC. Janian psychiatrists work at 30 different programmes across the city and in all CUCS housing services, in addition to the street outreach team, which has a psychiatrist embedded within the project. Janian recently expanded to provide primary medical care as well.

**Trauma-Informed Care (TIC)**

‘Trauma-Informed Care is a strengths-based framework that is grounded in an understanding of and responsiveness to the impact of trauma, that emphasises physical, psychological and emotional safety for both providers and survivors, and that creates opportunities for survivors to rebuild a sense of control and empowerment.’ (Hopper et al, 2010)

Many people who access homelessness services are likely to have experienced trauma, impacting how they relate to the world and others. A traumatic event is something which causes someone to feel terrified, helpless and a loss of control. It is the response to the event and not the event itself which is considered as trauma. The earlier trauma occurs, or the more often the individual experiences it, the stronger the impact.

The majority of CUCS clients have experienced multiple traumas, known as complex trauma. These people usually have other needs like substance misuse, suicidal tendencies, physical health problems and other mental health conditions. They are often diagnosed as having a personality disorder.

In the US there is a growing understanding that vulnerable children and adults are affected by past traumatic experiences and the use of a trauma-informed approach to supporting them is gaining momentum across different sectors.

There is a government department dedicated to it (National Centre for Trauma Informed Care) which delivers training and shares knowledge and best practice of how to implement the approach.

The key principles of a trauma-informed service are to create a safe and predictable environment in which support is personalised to the individual, focuses on their strengths and helps them to gain a sense of safety and control.

**Trauma-Informed vs trauma-specific**

It is important though to make the difference between trauma-informed and trauma-specific services. A trauma-specific service is therapy designed to help an individual deal specifically with the consequences of a traumatic event they have experienced. It is particularly useful for people with Post Traumatic Stress Disorder. However because people who have experienced complex trauma are so affected by it in every way, it is very difficult for them to engage in traditional therapy. Instead, they require unstructured therapeutic services and Trauma-Informed Care offers a broader approach; acknowledging behaviours as relating to trauma, minimising re-traumatisation and supporting people to gain insight to enable change.

As one team manager told me: “These clients aren’t ready to go to mainstream therapy. It is our job to prepare them to be ready.”

**Staff training and skills development**

Although TIC can be implemented in a number of ways, from changing the physical environment to introducing a framework for the culture of an organisation, it is commonly accepted that it is vital to provide information and skills to frontline workers who, in most cases, have the least education and training but most contact with service users. Through trauma focussed training, staff are able to provide their clients with the information and tool they need to understand and manage their symptoms and to begin recovery.

CUCS provides staff with information in two stages.

Firstly, they have introduced a core training day to all frontline staff, including management, and other employees who may have significant contact with traumatised individuals - maintenance teams, for instance. This particular course, Trauma and its Aftermath, is an information session. Staff are helped to understand the physical and mental impact of trauma, from a biopsychosocial perspective. With this scientific underpinning, staff are then able to understand how trauma
impacts the way an individual relates to the world, other people and services.

The second stage of CUCS’s implementation focuses on trauma-informed interventions, delivered via a forum set up with a voluntary representative from each frontline service. The aim is to teach the group a few easily learned and applied interventions, which can then be shared with their teams. More interventions are introduced over time.

The first interventions are around mindfulness, which is particularly useful with survivors of complex trauma, focusing on how to speak to people about their trauma from initial screening to ongoing support.

Having attended Trauma and its Aftermath myself, I spoke to staff and managers about their view of the training and its impact on their work. The response was unanimously positive. Having had the training, staff were taking things less personally, not seeing things in such a black and white way or feeling like they “couldn’t win.” The interactions between staff and clients has changed with staff now understanding they can’t fix the person but that they do need to be a safe and consistent presence.

One member of staff told me: “There are some people who are so traumatised they might never recover, but I need to consider how I can give them a better quality of life here and now.”

Staff are not afraid to use the approach. "It’s not as easy to cause harm as you might think," said one. "You will make mistakes but the real damage has already been done."

Managers advised me that the more staff learnt, the more they wanted to know, and that they had become less reliant on managers to step in and deal with issues.

Supporting staff

Another important aspect of TIC is the approach to supporting staff with vicarious trauma, where listening to someone talking about their trauma can trigger symptoms of trauma in the listener.

In the training, staff learn about vicarious trauma and how important it is to look after themselves as a priority.

Trauma-informed services provide a high level of support to their staff, with staff at CUCS having weekly supervision, usually for an hour a week.

However, at The Prince George, a permanent supportive housing project for 400 people, many with traumatic life histories, individual supervision has been increased to 90 minutes a week. This was in response to the impact of staff working with some of their complex trauma clients, providing more space to explore reactions to behaviours and dynamics in relationships.

In fact, a key trauma intervention is also being used to support staff. Managers have been learning and using mindfulness techniques in their meetings and have started to use them in team meetings with staff.

Ultimately staff were then learning the techniques which could then be shared with clients. CUCS teams are also provided with regular (mostly weekly) group clinical supervision by the onsite psychiatrist, with some being given access to individual clinical supervision for support with particular cases.

Safe and predictable environments

People who have experienced complex trauma are likely to have led fairly chaotic lives in which they have not felt safe or in control. Not only are their relationships likely to be with others who are leading equally chaotic lives, but they will also lack an internal sense of safety and control. It is therefore important for trauma-informed services to be safe environments in which there is consistency and in which rules and consequences are clear and adhered to.

Training staff goes a long way in ensuring that they create a safe and predictable environment or provide a safe and predictable service, as in the case of street outreach. If they understand that many of the interactions they have with clients, and the behaviours they observe, are indicative of a trauma response they will be able to consider why the person is acting in that way and will respond accordingly.

Transparency in service provision is also key to ensuring that clients feel safe and in control. Staff of the Scattered Site team, which provides floating support to individuals across the city, spoke of involving their clients, when no risk is posed to the worker, in all conversations relating to their needs and support. At The Prince George, staff are encouraged to speak openly with a client about future interventions that will be used when they are in crisis.

Medication distribution in communal areas at 350 Lafayette women’s shelter is another way in which transparency is increased. This shelter provides short-term housing to women with severe and persistent mental illness and low functioning ability. By providing medication in a shared space they have been able to normalise the process, which has increased compliance and awareness.
Managers at 350 Lafayette told me how, despite challenges relating to funding requirements, service delivery processes could also be made more trauma-informed. Examples included a member of staff building a rapport with a client prior to them moving in, to streamline the process and preparing the client to consider some of the scenarios they may experience in the shelter. Team members are also encouraged to read all the information obtained about the client before interacting with them, raising awareness of their history and triggers and preventing the client from needing to recount any traumatic events. It was also discussed that, where possible, assessments and support planning could be done at a later date when more trust had been established.

Transparency allows for clients to be clearly aware, in advance, of the consequences of their behaviour in different situations. For example a resident at The Prince George is asked to leave the staff offices as soon as their behaviour begins to escalate because other de-escalation techniques have not worked. This is a clear consequence which the client and staff are aware of, providing safe boundaries and preventing potential issues arising. Staff should always be direct in their communication with the people they support and should not underestimate the power of the individual to ask for what they need when given the opportunity to do so.

Client strengths and goals

In all CUCS projects, I was inspired by the way staff focused on a person's strengths rather than merely support needs and risks.

One worker advised me that it is much easier to build upon someone's positive behaviours than trying to get them to change. I was reminded by the manager of The Kelly, a transitional housing project, that an important part of being human is to have dreams and that staff encourage clients to have their own.

CUCS staff continually praise their clients and treat them with unconditional positive regard, asking clients what their own goals are and supporting them to work toward these. Rather than focussing on their own expectations - for instance, wanting a client to stop drinking - they work these goals into a person's larger goal.

Staff at the project also facilitate classes for recovery from mental illness and substance misuse. Not only do these classes provide individuals with coping strategies and focus on setting small goals, they also give clients a chance to learn other skills like how to get on with others and how to make small talk. In these classes, individuals are praised for their contributions and are often reminded how strong they are and how much they have survived in their lives. At The Kelly more people move successfully into permanent housing when the groups are running and they learn how to get on with others more successfully. At 350 Lafayette women's shelter, anything positive is shared among the residents. When someone is moving on to permanent housing, it is announced through posters and they hold a party to celebrate the achievement.

Trauma support classes

In order for someone with complex trauma to feel safe in the external world, they must first establish an internal sense of safety.

In some of the CUCS services, staff provide a curriculum of classes which have been adapted, from an evidence based practice, to suit people who would find the original curriculum too dense.

The classes, first provided just for women but now being delivered for men too, are tailored based on clients' known needs. They cover topics such as coping mechanisms, self nurturing and anger management.

At a permanent housing project I visited in Brooklyn, residents spoke warmly about how much these classes had impacted on their recovery from trauma and how a bond had formed between them.

"When people have been hurt so much, they don't even know what is possible for them," said one member of staff. Understanding things like "self nurturing" is difficult at first. For people who experienced pre-verbal trauma, staff at the Times Square project advised that art therapy groups are particularly successful in helping them to express themselves and begin recovery.

Mental illness and Trauma-Informed Care

According to psychiatrists at Janian, homelessness is very much seen as a symptom of mental illness. Unlike in the UK, where there is a common misconception that people who are homeless have made a lifestyle choice, many of those who give philosophical reasons for sleeping rough had been assessed, over time, as having schizophrenia.

All 40 residents at The Kelly, with their long histories of rough sleeping, have a psychiatric diagnosis (depression, mood disorders and schizophrenia) and most are on antipsychotic medication administered on site daily by a nurse. Because
psychiatrists are an integral part of the projects, they are able to build rapport quickly with residents and monitor changes in behaviour. Alongside these diagnoses many of the clients were considered to have a personality disorder as a result of traumatic histories. Janian psychiatrists often prescribe medication for co-occurring conditions such as anxiety and depression.

From a trauma-informed perspective however, diagnosis is less relevant as staff are trained to see an individual’s strengths rather than their mental illness. Through their understanding of trauma, staff can support their clients to understand that the symptoms they are experiencing are normal and attempt to help them to manage their anxieties. They appreciate that many clients self medicate through drugs and alcohol and, as a result, a holistic and harm reduction approach is required.

Floating support staff of the CUCS Scattered Site Program explained that many of their clients stop taking their anti-psychotic medication yet are still able to function. Because of this, the team consider chronic mental illness from a trauma perspective, acknowledging that behaviours displayed may be as a result of traumatic experiences and the individual trying to gain a sense of safety or control.

Applying learning in England

Many organisations for single homeless people in the UK are, often without knowing it, starting to work in a more trauma-informed way. However, talking explicitly about trauma as the underlying support need enables staff and clients to better understand behaviours and move towards recovery. Although we can never prevent people from becoming traumatised, we can ensure that when they come into contact with a service provider, that provider works hard to ensure that the individual is supported to start regaining what was lost as a result of trauma, and that the possibility of re-traumatisation is minimised.

When someone’s inner sense of chaos is reduced, they are less likely to go into crisis and more likely to use homelessness services and other services appropriately. As a result, episodes of repeated or long-term homelessness are likely to reduce as is the subsequent financial cost of working with this complex client group who repeatedly use different services ineffectively.

Since returning to England, I have made contact with a number of people within and outside my own organisation with a view to discussing my findings and how I could potentially take it forward. When I meet with people within my organisation I will advocate that all frontline staff and managers need to learn about trauma and trained in interventions to use, and would recommend that the focus on support and supervision is increased.

It would also be fantastic for the three evidence-based recovery groups to be rolled out across accommodation services. I firmly believe that TIC could easily be widely shared and implemented across my own organisation and other sectors and I have been approached by a variety of people who are interested in learning more about it. For this reason, Homeless Link or another national organisation could take the lead in providing knowledge, best practice, consultancy and training to staff and organisations across the UK working with this client group.

I am keen to be involved in sharing this practice more widely, having seen first hand the impact of staff education, client groups and the embedded nature of a trauma-informed approach within CUCS’ services. CUCS provided me with all of the training documents and class curriculums and are happy for me to contact them at any time. In addition, I have booked myself on two short courses which I believe would be beneficial in taking this forward; one focusing on training adults and another about new therapeutic interventions for individuals with complex trauma.

I plan to create a toolkit but feel there is much more to learn, particularly around interventions that can be used. Throughout and since the exchange I have used Twitter, @joanneprestidge, and my blog, http://joprestidge.wordpress.com to promote my experiences and learning. My blog posts have been read and shared by individuals and organisations working across the sector. The CUCS communications team also interviewed me for a guest blog which is yet to be published and I will be presenting my findings at a trauma event organised by Homeless Link in September.

Finally, I have been implementing a trauma-informed approach in my own work and discussing client behaviours from a trauma perspective with my colleagues.

Understanding trauma, and reframing my clients’ behaviours from this perspective, has led me to feel more empowered in my role and more confident in the support I can provide.

Conclusion

Due to reduced public funding, but a growing awareness that homelessness is very much linked to health, TIC is a cost effective and easily replicable approach that can be used by the homelessness sector, and others, working with individuals with complex needs.
Understanding trauma explains why other approaches, like personalisation and harm reduction, are so successful for this population.

Trauma is a shared, but not widely considered or understood, support need which impacts how a person engages with the world. By empowering staff with knowledge of trauma and the appropriate skills, clients are engaged holistically and supported more successfully, they stay in services for longer and are able to take control of their own recovery.

We cannot expect individuals with complex trauma to access mainstream services if they are not yet ready. As a sector we need to provide them with unstructured therapeutic services which slowly prepare them for this.
Dorota Strzelecka
Housing First for people with dual diagnosis
Host: DESC
Location: Seattle
While both the USA and the UK face a homelessness problem, the two countries have different approaches to tackling it.

In my research I wanted to explore whether Housing First is an effective method of housing chronically homeless people with a dual diagnosis who do not succeed in the traditional transitional housing model, and compare it to practice back in the UK. As defined by the USA Department of Housing and Urban Development a ‘chronically homeless person’ is someone who has experienced homelessness for a year or longer, or who has had at least four episodes of homelessness in the last three years and has a disability (which can refer to their behavioural condition, including severe mental health illness and substance misuse problems). This client group pose a particular challenge to housing providers due to their complex needs, often relating to trauma, drug or alcohol addiction and/or mental health problems. In my research I wanted to explore how these difficulties are resolved, resulting in successful housing retention.

This question is very relevant to my role – I work in supported housing as a junior manager and at times I need to make difficult decisions which have real consequences to the clients and their housing situation. Generally my work focuses on helping people to achieve or sustain housing independence. I work with people who are offered accommodation in one of our accommodation-based projects and with those in the community who are at risk of losing their home. Although there are many successes, I have witnessed people losing their accommodation due to breaches of tenancy as a result of behaviour rooted in the complexity of their needs. Housing First methodology offers a different approach to housing complex clients and it has been very successful in the USA. I wanted to explore the principles of this model and see if they can be transferred and utilised in the English framework.

The traditional model of supported housing is based on the idea that clients are ready and willing to engage with the service and that they are capable of addressing their issues. Many of the requirements for supported housing include the willingness to engage with the support offered, participation in therapy or substance misuse programmes or engagement with mental health agencies with an aim of overcoming the issues preventing the person from acquiring or sustaining their tenancy. A person is required to go through various stages of the housing ladder to prove their housing readiness before they are offered their own tenancy. Housing readiness is defined by local authorities who, due to low housing stock, need to ensure that the placements are successful and so have strict eligibility criteria. This ladder is extremely difficult to climb for individuals who have never experienced having a tenancy or whose needs are too complex to be addressed in a relatively short space of time. This group is unable to secure long term tenancies as they cannot meet the obligations detailed by supported housing contracts dictated by local authorities due to their complex needs and chaotic lifestyles.

Housing First turns this traditional model of housing upside down by stating that housing is a basic human right that should be available without any prerequisites of engagement with treatment. Clients are offered accommodation first in belief that ‘providing a person with housing first creates a foundation on which the process of recovery can begin’. Housing First approach presumes that: ‘once the chaos of homelessness is eliminated from a person’s life, clinical and social stabilization occur faster and are more enduring’. Stable housing also works as a ‘motivator for consumers to refrain from drug and alcohol abuse’.

I wanted to explore how such a model is delivered by focusing on four key problem areas the model may pose:

1. Multi-agency, comprehensive and specialised support package – how can such individualised support be delivered? The Housing First model is renowned for the robust and individualised support package tailored to the needs of the individual. How is it delivered?

2. Engagement – what is the best way to engage people who have been classified as 'not housing ready'? As engagement acts as one of the core values of supported housing how can providers offer housing and not require engagement?

3. Community expectations vs housing management – how can people be supported in their tenancies while keeping the community around them happy? Managing complex clients in the community poses problems which can jeopardise tenancies – how can that be managed on a day to day level?

4. Cost-effectiveness in comparison to the transitional housing model. Research demonstrates that Housing First is a less costly option to supporting people who are chronically homeless than not offering them housing at all – how is this possible and would it be true in England?

To answer these questions I travelled to the USA to get to know the ins and outs of the Housing First model firsthand.

I was hosted by Downtown Emergency Services Centre (DESC) in Seattle, WA which is the largest multi-service agency serving homeless adults in the Puget Sound region. They support over 2,100 people daily through an array of clinically based programmes, shelter and housing. They run 279 emergency shelter beds and over 800 units of permanent supportive housing. DESC’s mission is to end homelessness.
among the most vulnerable people of Seattle by delivering "an integrated array of clinical services and supportive housing that allows men and women to reclaim their lives and reach their highest potential". They were among the first organisations in the USA to implement the Housing First model. Thanks to their pioneering approach to tackling homelessness, DESC has received national recognition for its work with chronically homeless adults with behavioural health disorders. Its approach was underpinned by creative and flexible delivery of the services to reflect the complex needs of their clients and as a response to the lack of appropriate resources available elsewhere.

Multi-agency, comprehensive and specialised support package - how can such individualised support be delivered?

One of the first questions I asked related to the highly specialised support package required to work with people with severe mental health issues and chemical dependency problems. My hypothesis was that such consumers would require a lot of input and monitoring from various agencies and housing. I wanted to get to know how such comprehensive multi-agency working is managed to achieve good outcomes for clients.

DESC rarely works with agencies specialising in secondary (behavioural) services. Instead, they deliver specialised support internally through a variety of clinically based programmes managed and designed by DESC.

DESC obtained a mental health licence in 1984. Traditional behavioural services underperformed as they failed to recognise the difficulties DESC clients were having in adopting a structured, planned and well-managed attitude to engagement due to their poor mental health and deeply embedded addictions. DESC chose to deliver the support internally so that the programmes and the policies could be built around clients' needs so that the chaotic patterns would not constitute a barrier to obtaining a service.

DESC teams are prepared to work on clients' terms and in their own tempo: discharge timescales are much longer in comparison to community based teams, the meeting pattern does not have to be as regular and it doesn't have to follow structure.

DESC delivers some chemical dependency programmes and many mental health programmes including HOST, SAGE and PACT. These are highly specialised mental health teams associating various professionals from the field e.g. nurses, psychiatrists etc.

They work flexibly with the client and at the client's pace. They deliver so 'in vivo' care, which is based in an individual's environment (e.g. on the streets) and not in designated centres, where the environment can be intimidating. The programmes differ in terms of eligibility criteria and the amount of support offered to clients. HOST will reach out to people on the streets and work on service engagement and getting people interested in the idea of being housed; PACT will deliver intensive support post-hospitalisation; and SAGE will provide low level, monitoring support and ensure that clients stay linked in with the services. All teams work to a common goal – to break the cycle of homelessness for their patients and to improve their health.

In addition, DESC works with benefit agencies to ensure that their clients are able to manage their income sufficiently. If DESC are concerned that a client mismanages finances to the extent that it poses risks to themselves (e.g. financial abuse from others), DESC and the client can discuss that with the benefit agency and apply for payeeship where DESC act as a named person for the client, resulting in improved financial management for the client. Also, DESC supports clients to access appropriate primary care – they discourage clients from using emergency rooms as means of getting treatment and encourage them to attend appointments in local clinics, often with staff support.

Moreover, the staff supporting their accommodation based projects are highly specialised personnel. Clinical Support Specialists are professionals with social work or mental health background who are able to mentor and engage with difficult population. They take primary responsibility for the support package offered to the client and ensure that clients' needs are met. They seek out additional resources as required and ensure financial stability and appropriate medical attention, including behavioural support. They will refer to DESC clinical teams to ensure specialist support and work alongside each other to deliver a unified support package. They work alongside Residential Counsellors who are on the premises 24/7 and whose duty is to respond to behavioural or health crises, resulting in fewer hospital admissions and minimal disruption caused by anti-social behaviour.

By delivering support internally, DESC’s philosophy is not overridden by the rules of external service providers with conflicting views on service delivery and client engagement. I found it particularly fascinating as through this approach DESC is able to deliver a unified message based on the principles of Housing First and in line with its core values across its services.
Engagement – what is the best way to engage people who have been classified as ‘not housing ready’?

One of the most controversial features of Housing First approach is the idea that an individual can access housing without any prerequisites, such as initial participation in psychiatric treatment or treatment for sobriety. It is about housing, not engagement.

More traditional models of transitional housing are based on the idea of ‘treatment first’ where a client needs to evidence their willingness to change their situation and address their issues before they can be offered housing. Housing First works against this ideology by redefining housing as a human right.

This attitude is deeply rooted in the idea that everyone wants to be well and healthy but, due to their behavioural conditions, their motivation or capacity will not allow for healthy choices. Housing First is about giving people time to get better and then revisit their needs.

Staff can have expectations of their clients to achieve their full potential, but they don't mandate it. Workers often find that chronically homeless people want to be housed but they refuse compliance with the conditions imposed on them by agencies offering housing e.g. sobriety. People respond well to projects run on principles of Housing First. Once stabilised and settled, they are more likely to open up to a necessary dialogue with support providers, and to start to negotiate their needs.

DESC's practices are guided by a harm reduction approach described by Alan Marlatt, George A. Parks, and Katie Witkiewitz in their paper on Relapse Prevention Therapy.

The harm reduction approach is an attitude to managing harmful behaviours and reducing its harmful effects on the individual and the community where chemical dependency is seen as clinical rather than criminal matter.

Housing First is not “housing only” – staff will try their hardest to engage clients with the support by gaining their trust and moving at the client’s pace. To do that they will use an array of creative techniques to build a positive relationship with a client, e.g. offering tools, clothing, support in accessing health care and so on.

In addition, DESC runs HOST outreach services which aim to start the engagement with the most entrenched in homelessness. The team will meet people who are not currently engaged in services, and spend days sitting with them and acknowledging their beliefs in order to build rapport. One of the roles of HOST Outreach is to increase readiness and willingness in further engagement with services. Once the client has built trust in their support worker, they are more likely to accept housing with their recommendation and support.

It is important to stress that in the Housing First approach the engagement is not compulsory. Clients will not fail because of lack of engagement, unlike in traditional services. The focus is on housing retention, not on progression. Also, the traditional barriers put in place by housing providers suggest that people who are ‘not housing ready’ are dropped, in favour of the belief that once clients have a stable home to go back to, they are more likely to successfully engage with treatment and mental health services.

Community expectations vs housing management – how can people be supported in their tenancies while keeping the community around them happy?

During my trip I intended to find out how DESC manages the potential conflicts between their projects and the community around them. There is a certain stigma attached to the people they serve and I wanted to find out how they overcome such issues.

It seems that DESC puts a lot of work into selecting the right place for their project – they research the market and choose the right neighbourhood with plenty of local amenities and access to public transport. The motto is ‘would I like to live in there?’.

Once the project is on the go they engage in an extensive dialogue with the local community and educate the neighbours on the real impact of DESC investments (house prices go up!) and their work.

They attend Neighbour Advisory Groups and address issues arising and challenge the stereotypes. Interestingly, they link in the new neighbours with people from nearby established projects, offering a type of peer-support group within the community. Once the projects are developed they sustain positive relationships by offering support with a 24/7 on call service or in case of anti-social behaviour caused by clients. Also, they look for ways to involve clients in communal activities. They encourage neighbours to welcome clients into such activities, working to ensure positive integration and community involvement.
Cost-effectiveness in comparison to the transitional housing model

Research clearly states that when all costs are taken into consideration, permanent supportive housing is a more cost-effective way of supporting chronically homeless. To illustrate, the participants in the 1811 Eastlake program (a DESC owned property) cost $2,449 less per person per month than those who were in conventional city shelters10.

This was confirmed by research featured in the JAMA journal which concluded that, for the high users of emergency services, this model of housing was associated with a relative decrease in costs after 6 months and these benefits increased to the extent that participants stayed in housing longer11.

A similar correlation was not noted in permanent supportive housing projects which focused on housing the most vulnerable people who were not high utilisers of emergency services. However, the value of offering housing to this group focused on fewer psychiatric hospital admissions, stabilising people in housing and reducing the problem of homelessness in the community.

Applying learning in England

Realistically, if Housing First is to be implemented into the structure of the local housing landscape in England, local authorities and the commissioners must recognise the benefit of this model both socially and financially.

Demonstrating the cost effectiveness of the model is difficult due to the lack of data demonstrating potential overall cost savings12. It is difficult to pinpoint the costs of homelessness, as many individual characteristics and circumstances (like mental health issues, offending, substance misuse) both lead to, and are perpetuated by, homelessness13.

However, some assumptions have been made suggesting that the cost of supporting high needs clients in accommodation are considerably lower than the costs associated with the same person without appropriate support in place: £24,350 per person per year if in receipt of support (direct government expenditure only) in comparison to £407,500 without support in the extreme case14.

Housing First models require a long term and secure stream of funding. These projects need to last a lifetime and cannot be decommissioned after two to three years of operation, therefore short term funding is not suitable. To secure long term funding, local commissioners (social services, NHS) should be involved and educated about the positive outcomes to clients and society so that they are willing to participate. More research into the effectiveness of the model is needed to encourage commissioners in the sector to invest.

Housing First principles cannot be implemented immediately into the current transitional housing model, as providers would not be able to meet their terms of contract with local authorities, which focus on moving clients on.

These services would need to be commissioned on Housing First principles and the clients accessing the service must be carefully selected to ensure the most vulnerable are assigned housing first. However, the positive practices of not discriminating against someone based on their offending or substance misuse history can be applied immediately. Similarly, seeking creative solutions to support delivery and achieving outcomes over a longer period of time can result in better relationships with clients and improved quality of support.

In addition, housing support teams could be more diverse and include a more specialised workforce with specific medical/mental health backgrounds. This would add new perspectives to the team and it would increase its multi-disciplinary profile. Providers can always cultivate the working relationships with secondary services in the interim.

Another challenge that might be faced by providers is obtaining suitable housing stock. In general, we need more affordable housing in England, as accommodation costs are high. Financial support is available, in the form of housing benefit, but in many places Local Housing Allowance is not enough to cover the rent in a competitive rental market. Private landlords are not always willing to risk offering accommodation to people with complex needs, even with a support package attached - whether because of the risk of damage to property or complaints about anti-social behaviour. When the market is saturated this allows landlords to be ‘picky’ in the choice of tenants they accommodate.

However, local support providers are keen to explore the model and see if its principles could work in England. My organisation, Two Saints, is currently implementing a Housing First pilot through Poole Accommodation Service, in conjunction with Poole Borough Council. They offer three placements to the most entrenched rough sleepers with complex needs who have struggled to settle in supported accommodation.

In this particular case Two Saints acts as a coordinator between the landlord, the client and the service provider to sustain the tenancy. The service – normally based on finding accommodation and a tenancy intervention scheme – is
responsible for negotiating the conditions and any issues that arise between the parties. Two Saints has engaged a local floating support service to deliver high level tenancy sustainment support. They have also done a lot of preliminary work with the landlords who are aware and understand the complexities of the clients they are serving. Careful selection of the landlords and transparency about support needs ensures that the landlords will not take the decision to terminate tenancies quickly.

In addition, staff ensure that the location is matched to the needs of clients (e.g. separate entrance to the building, adequate area). The team have established good working relationships with neighbours and local Anti-Social Behaviour Team, and they manage mediation if conflicts arise.

Like the practice in the USA, engagement is not compulsory, although it is preferred. The teams will use various techniques to encourage clients into positive engagement. If this model proves to be successful, it will be expanded.

On a personal level, I have published my findings in an online blog detailing my experience. I will be sharing my learning outcomes with the Senior Management Team in order to promote the principles of Housing First. I am keen to promote the model externally.

**Conclusion**

Housing First is an innovative and forward thinking effort to end homelessness among chronically homeless people with dual diagnosis.

The ten projects managed by DESC are a good example illustrating the effectiveness of the model which is based on the multi-disciplinary support delivery and anti-discriminatory policies in the service. This model works particularly well for entrenched clients who struggle to adjust to living in transitional housing. Transitional housing, on the other hand, can be a good tool to supporting people with lower needs and whose problems can be resolved in the short term.

The practice in the USA differs greatly to the practice in the UK, as the latter tend to focus on temporary transitional housing and not permanent support. Permanent support has not yet been fully implemented in Britain although providers are keen to explore this model.

The UK offers a lot of positives in terms of fighting homelessness on a lower level by providing housing subsidies (Housing Benefit) for example. Both UK and USA see the success of clients in similar ways – meaning that both sides focus on improving the quality of life of clients by improving their financial and health situation, improving links with family and ensuring clients have place in the local communities – physically in terms of housing and socially in terms of engagement in the local life.

My personal lesson from the Exchange was to look at the current practices and be more critical of them – to notice the positives and to try and break the barriers to housing with clever and creative risk management planning and support delivery. It helped me see that things can be done differently and encouraged to take positive risks – controversial does not have to be wrong. It also promoted further research on promising practices as these can always bring new ideas to improving the quality of the service delivery.

**References**

1. www.endhomelessness.org/pages/chronic_homelessness
2. Tsemberies, S., Gulcur L., Nakae M. (2004): Housing First, Consumer Choice, and Harm Reduction for Homeless Individuals With a Dual Diagnosis,
3. www.endhomelessness.org
4. Tsemberies, S., Gulcur L., Nakae M. (2004): Housing First, Consumer Choice, and Harm Reduction for Homeless Individuals With a Dual Diagnosis
5. www.desc.org/homelessness.html
6. www.desc.org/index.html
7. www.desc.org/homelessness.html
8. www.desc.org/housingfirst.html
11. Mary E. Larimer, PhD; Daniel K. Malone, MPH; Michelle D. Garner, MSW, PhD; David C. Atkins, PhD; Bonnie Burlingham, MPh; Heather S. Lonczak, PhD; Kenneth Tanzer, BA; Joshua Girzler, PhD; Seema L. Cfifasefl, Phd; William G. Hobson, MA; G. Alan Marlatt, PhD (2009): Health Care and Public Service Use and Costs Before and After Provision of Housing for Chronically Homeless Persons With Severe Alcoholic Problems
12. St Mungo’s: Opening Doors for Homeless People (July 2013): Health and homelessness: Understanding the costs and role of primary care services for homeless people
Ben McDonnell
Permanent supportive housing

Host: SHNNY
Location: New York
Permanent supportive housing (PSH) is a US model of housing used to house people with experience of homelessness who also have other complex needs, such as severe and persistent mental ill-health and/or substance misuse issues.

Developed in New York in the 1980s, PSH is widely regarded as an effective approach to ending homelessness among this group. It is based on the principle that permanent, affordable housing, with the availability of tailored on-site support services, gives people the necessary housing stability to truly transition from homelessness, manage their needs and integrate into their communities.

**Accommodation supply in England**

Faced with limited resources and reduced funding, high demand for supported housing options and the high cost of providing temporary accommodation, local councils in the UK are increasingly directing people to rent in the private sector.

This raises questions about the sustainability of accommodation options for people with housing related support needs. I see levels of repeat homelessness in my daily work that services need to address. The costs of repeat homelessness might be reduced if we can learn lessons from understanding the cycle of falling in and out of homelessness - and adopting a new approach to the problem.

A particularly vulnerable person can find it difficult to maintain a private tenancy. With no obligation on services to provide additional support to stay in their accommodation, they are obviously at increased risk of losing it.

I don’t believe the UK supported housing model is always the best option for these people. At No Second Night Out London we frequently offer support to people who have been sleeping rough, but who have previously been in Local Authority supported housing.

These people have been evicted from one hostel and moved to the next and the next because of their behaviour. As a result they have not completed their programme of support and have not been deemed housing ready. What is missed is that the behaviour that leads to their evictions is directly related to their complex needs. They never experience housing stability because they haven’t recovered or transitioned from homelessness.

Hostel placements are most typically offered on a licence agreement which can be ended with ‘reasonable notice’. By definition, such a tenure is insecure and runs the risk of that person experiencing episodes of repeat homelessness.

**Learning from the US**

High rates of repeat homelessness, particularly among vulnerable groups, suggests that the types of accommodation offered to people with experience of homelessness is not working for them.

Better and more cost effective outcomes might be achieved by exploring and adopting alternative approaches.

With greater security of tenure and tailored supportive services, permanent supportive housing is an alternative solution to homelessness, delivering positive outcomes, such as high retention rates and net savings against more costly emergency services.

I chose to research permanent supportive housing with the following learning objectives:

1. To fully understand the permanent supportive housing model, its inception, processes and outcomes
2. To identify the eligibility criteria for accessing it
3. To develop an awareness of the financial models underpinning it
4. To assess the cost effectiveness of permanent supportive housing and the political push to secure units
5. To evaluate the benefits to the service user
6. To identify practice areas that could be replicated in the UK

**The US context**

The scale of homelessness in New York City is vast. With the legal right to shelter established following a court ruling in Carey v. Callahan in 1979, NYC in 2014 is currently experiencing unprecedented levels of demand for its shelter provision.

The cost of homelessness services to NYC is $1.1 billion each year. Like London, the availability of affordable rented accommodation is far outstripped by demand. Over recent years, the gentrification of New York’s neighbourhoods has limited the availability of affordable housing and real term salaries have not kept up with the cost of living. Many more

It costs $3,000 per month to shelter a family, with an average length of stay of 400 days. The US Department for Housing and Urban Development reported in the 2013 point in time count that there were 3180 people sleeping rough in NYC on a given night. This number is predominantly made up by people who refuse to access shelter because of perceived risk or previous experiences and those who are ineligible because of complex immigration matters.

The cost of homelessness services to NYC is $1.1 billion each year. Like London, the availability of affordable rented accommodation is far outstripped by demand. Over recent years, the gentrification of New York’s neighbourhoods has limited the availability of affordable housing and real term salaries have not kept up with the cost of living. Many more
people are now experiencing homelessness as a result of economic factors. At the Supportive Housing Network of New York (SHNYY) 2014 annual conference, Commissioner Banks of the NYC Department of Human Resources said that 25% of sheltered families had an adult who was working full time.

New York City elected Mayor De Blasio in early 2014. Under this new administration, the city is committed to develop a housing strategy that meets the needs of its evolving demographics. **Housing New York** is a ten year housing strategy with optimistic targets of investing in 200,000 units of new affordable housing for the city.

During the Network conference there was talk of rent stabilisation, a NYC policy to preserve the affordability of its housing stock, a commitment to thriving, mixed income neighbourhoods and investing money upstream to prevent homelessness. The commitment to increasing the supply of affordable accommodation, meeting the housing needs of the most vulnerable New Yorkers and investment in preventative services comes from the NY/NY Supportive Housing Agreement.

The current agreement signed in 2005, NY/NY II, is a ten year commitment from city and state to eliminate homelessness among people with poor mental health and other vulnerabilities. NY/NY III includes funding for the development of 9000 units of supportive housing and coordination of a range of government agencies, housing providers and social services.

**Supportive Housing Network of New York**

My exchange placement was hosted by the Supportive Housing Network of New York. The Network is a grassroots, membership organisation representing over 220 supportive housing providers across New York City and State. It provides membership services, which include advocacy, training and sharing best practice. The aim is to continually improve the model and maintain it as a resource for ending homelessness.

The Network plays an important role in sharing policy changes with its members and interpreting its impact, by listening to its members’ frontline responses. They also influence government decision makers by increasing awareness to ensure continued investment in services.

The Network has been successful in advocating for the development of a successor agreement to NY/NY III, with language supporting a successor agreement included in the Mayor’s ten-year plan and support of a new agreement was announced to its members at The Network’s annual conference in June 2014. By listening closely to its members, the organisation is able to identify the challenges facing providers and gaps in service provision through which it is able to advocate for additional resources. An example of this is the role it played in collating evidence and baseline data for youth aging out of foster care. The data was used to expand access to supportive housing for this group and negotiate a policy change to include a discretionary year extension to the age criteria for those having difficulty moving on from PSH.

**Findings**

Permanent Supportive Housing was first used as a housing model in New York in the 1980s, the first of its kind being a run down single room occupancy building bought by Franciscan Fathers and renovated through private funding.

Psychiatrists and caseworkers volunteered their time to provide on-site services. Similar experiments were underway in other parts of the City, as non-profit providers realised that vulnerable people needed both a decent place to live and support to remain housed. Since then, the model has developed to meet the continuously evolving demographics of New York’s homeless population.

New York State is now the biggest provider of Permanent Supportive Housing in the United States, delivering over 47,000 units and with a commitment to expand this further. New York’s current administration has committed to developing or preserving 200,000 units of affordable and supportive housing in ten years. PSH is regarded as a cost-effective solution to homelessness that reduces spending on more costly interventions such as accident and emergency departments and inpatient psychiatric units.

One element of the PSH package is a permanently subsidised rental agreement. Tenancies are offered on a permanent basis - often let on a one year starter tenancy which is renewed on an annual or biannual basis providing the accommodation is managed according to the agreement. The stock is rent stabilised meaning that rental costs increase on an annual basis in line with NYC’s guidelines which generally range between 1% and 6%. Occupants are required to contribute a third of their income to rental costs, be that through salary or benefits, with the remaining rent made up by the subsidy.

This is a fair and somewhat progressive approach, however, it has limitations as the subsidy is not a universal benefit. To qualify for PSH, a tenant must meet one of the defined disability criteria to qualify for the relevant benefit to subsidise their housing costs. To add further complication, units tend to be assigned to a particular funding stream restricting access for those not eligible for the specified type of funding.
Focusing on its current position, the majority of funding for permanent supportive housing comes from NY/NY III, with capital funding for the programme split 50/50 between city and state. NY/NY III was developed initially to address the issue of chronic homelessness. The populations targeted by the agreement include those with a diagnosis of severe and persistent mental illness, physical health problems, those with substance misuse issues and young people aging out of care. Parallels can therefore be drawn with the UK as the targeted populations would be those who would likely be owed a housing duty by their local authority or who would have the necessary needs to access supported housing.

Permanent Supportive Housing operates on two core models:

- **Single Site**: these projects are newly developed or regenerated buildings of self-contained studio or one-bedroom apartments, with a median of 70 units per building with onsite support services.

- **Scattered Site**: self-contained, dispersed, open market studio or one-bedroom apartments with floating, wrap-around support services.

I had some reservations about the single-site model, especially in the larger buildings housing upwards of 150 people with complex needs, and questioned how appealing and sustainable such an option might be for an individual or a community. There is a fear that such accommodation is another form of institutionalisation and it is a criticism of the PSH model that The Network and providers educate critics about. As a result of a 1999 Supreme Court Decision in Olmstead v. L.C, US states are required to provide individuals with disabilities accommodation in the least restrictive setting possible. Advocates for supportive housing maintain that single-site supportive housing is the embodiment of the type of housing Olmstead sought to create in that individuals have tenant rights and services are voluntary. These types of residences strive to be as much like a standard apartment building as possible.

While scattered-site supportive housing is considered fully integrated as they are open market units dispersed throughout communities, cities with limited housing stock must develop new housing in order to begin to meet the need. This model also has limitations as to the extent of services and support that can be provided. Providers are heavily reliant on a client’s engagement and it is therefore not a solution for everyone.

Common Ground, The Lee – single site, Lower East Side, Manhattan

Common Ground is the largest provider of supportive housing in New York with 13 buildings providing 3000 units of PSH. They operate other services including transitional housing programmes, a scattered site programme and street outreach services. The Lee provides 264 single units of accommodation to homeless individuals and low-income households at an average unsubsidised cost of $640 per month. This level of rent would be most comparable to a social rent provided by local authorities and housing associations in the UK and is affordable relative to income and Manhattan’s market rents.

One of the most prevalent principles of PSH is integration. The Lee’s population is therefore made up of 69 units for those who are chronically homeless with mental ill-health, 35 units for those chronically homeless with HIV/AIDS, 56 units for youths aging out of foster care and 104 units for the general needs low-income population. The units are not segregated and therefore the accommodation feels like any other new build apartment building. This level of integration is common across all PSH single site services and contributes to building a sense of community, allowing individuals to achieve housing stability in mixed communities. Most PSH models operate with no greater than 60% of their residents coming from NY/NY III populations and this goes a long way in appeasing critics and satisfying them that PSH is housing first and foremost.

Integration with the wider community is also important. When buildings are proposed, service providers often face a backlash from local residents with a ‘not in my backyard’ attitude. The Network and providers therefore promote permanent supportive housing through public education and sell a building’s contribution to the local neighbourhood, an example being the Furman Report, a study evidencing that PSH buildings raise property values in their immediate locale. Affordable units not funded by NY/NY III are open to applicants from the local area, with an income of no more than 60% of the area median, on a general needs waiting list basis. Further to this, some providers also offer additional benefits to the local community. Broadway Housing Communities, for example provides cultural and educational services to local residents, such as a pre-school for children from low-income households at one project in Harlem.

Access to PSH for the homeless population is through two main routes with providers using one, the other or a combination of both. The NYC Department of Human Resources Administration (HRA) uses a common assessment framework to allocate an appropriate unit of PSH to those in shelter. Street Outreach teams will also case manage people sleeping rough, gathering the necessary documents for individuals to evidence their eligibility for income benefits and eligibility for NY/NY III funding. Once evidenced, they are able
to present a person’s case to one of the central Intake offices of the HRA whereby a unit will be allocated on a Housing First basis to those moving into accommodation directly from the street. Housing First removes the requirement to be deemed ‘housing ready’ i.e. medication compliant and sober, and will make accommodation available regardless of where the client is in their trajectory.

The primary function of PSH is to provide affordable, permanent accommodation to those in housing need. However, fundamental to its success in providing sustainable housing is the addition of high quality supportive services to residents. Single site residencies are equipped with on-site building management and security staff. Responsible for tenancy management, lettings, rent payment and tenancy violations they work in partnership with providers of social services to give tenants the necessary support to stay housed, get healthy and reconnect to the community. Services are not compulsory but available to residents as and when they choose to engage, operating on a harm reduction model.

Models differ across sites and providers. Common Ground, for example, works in partnership with the Centre for Urban Community Services (CUCS) to deliver on-site support services to their tenants. The support provided is tailored to each individual and delivered by multi-disciplinary teams including case managers, social workers, employment specialists and psychiatrists.

More commonly, providers directly employ social work professionals and case managers to work alongside their building management team. In both instances they work in partnership with the shared goal of supporting tenants to maintain their accommodation and access appropriate services according to their needs, including but not limited to:

- Drugs and alcohol counselling
- Access to primary health care
- Secondary mental health treatment
- Signposting to external services e.g. detox
- Employment and skills coaching
- Income maximisation
- Eviction prevention

I was also surprised at the additional non-clinical services offered to residents including cooking groups, arts and craft and skills coaching and the way these are used to engage with clients and monitor their well-being. For those harder to reach clients who did not wish to engage with drug and alcohol support, for example, these alternative groups provided good contact time for staff and residents in an informal environment.

One of the biggest challenges in my work is coordinating the responsibility of housing professionals, mental health services and social services. In the UK, we have the foundations of a good social support system, including free health care and legal obligations to formally assess and offer assistance to vulnerable people. However, my opinion is that statutory services do not always take a holistic approach to meeting someone’s needs. Faced with restrictive budgets and increased tightening of eligibility criteria, services can sometimes miss opportunities to prevent homelessness and the deterioration of someone’s mental and physical well-being.

PSH is evidence that coordinated tenancy sustainment and support services are crucial to housing stability for those with complex needs. Common Ground, for example, cite retention rates of 95% and eviction rates of less than 1%. Not only does PSH promote housing stability, improve health outcomes and reduce episodes of repeat homelessness among some of the most vulnerable people, it reduces costs against more costly interventions such as accident and emergency, in-patient admissions and prison.

Move on from PSH for those who may no longer require the support is complicated due to a lack of affordable housing options and restrictive housing subsidies. As no universal housing benefit exists, a tenant may not be able to move out of their subsidised unit because they are not able to access an alternative subsidy such as Section 8, for example. However, following an interesting conversation with the Director of Operations at Common Ground, I understand that PSH continues to provide essential affordable housing to those who become stable and the availability of on-site support continues to provide a safety net should that person relapse.

Applying the learning in England

A key learning for me from this experience is that ‘housing is the solution to homelessness’. This seems simple enough, but our traditional pathways set prerequisites to housing including abstinence and treatment and the need for someone to assess you as being ‘housing ready’.

In one London borough, this approach is rigorously applied to the point that to access supported housing because of a substance misuse issue, you must first commit to clinical detox. For a street homeless person who has disengaged with services, this can be difficult to face. Services do not like to run the risk of someone relapsing post-detox and expect a period of engagement with their service to prove commitment to abstinence. I would argue that this has the potential to exacerbate an existing issue by sustaining that person’s homelessness. Better and more cost-efficient outcomes may be achieved by a widespread Housing First approach as pioneered by the US and currently being evaluated in the UK.
Repeat homelessness amongst some of the most vulnerable populations is perhaps one of the most concerning aspects of my current role. The lack of appropriate support to people placed in temporary accommodation under an interim or full housing duty means that we fail to safeguard some of the most vulnerable adults. Since returning to No Second Night Out (NSNO) it has been a priority for me to improve practice in this area. NSNO staff could play a more powerful role in ensuring those placed in temporary accommodation by the local authority have been referred to appropriate support services such as generic housing related floating support, GPs, CMHT and drugs and alcohol services. We also need to play a greater role in encouraging the local authority to take on these additional responsibilities. At a more strategic level, NSNO could use case studies to highlight gaps in provision to influence local authorities to adopt good practice protocols in this area to ensure vulnerable people are placed in accommodation suited to their needs with adequate support.

I intend to meet with providers of Housing First in London to discuss my learning and share good practice. As these are newly commissioned services, there is real opportunity to contribute to their development with some of the practice learnings from existing services in the US.

Scattered site PSH is most replicable in the UK, in fact some PRS Access Schemes deliver similar services by providing ongoing floating support for the lifetime of the tenancy if necessary and taking a responsibility for coordinating access to other specialist services. This good practice could be built upon and shared more widely, for example, by providing such a service to those in temporary accommodation.

Single site PSH would be more difficult to transfer to the UK. Developers in the US use Low Income Housing Tax Credits to fund new buildings with capital contribution from NY/NY III. Realistically, the funding of such developments is unlikely to be replicable in the UK. We would be better placed investing in truly affordable rented housing that is available to not only those with experience of homelessness but to those in need of low cost homes, adapting a similar principle to PSH and removing the stigma of homelessness and reliance on homelessness services.

Conclusion

Permanent Supportive Housing has existed for over thirty years and the model has evolved throughout that time to meet the needs of NYC's homeless population and to respond to political priorities for ending homelessness. PSH and its providers have helped to shape policy by providing evidence of the needs of those with experience of homelessness and have developed accommodation options to meet those identified needs.

The cornerstone of PSH is that permanent, affordable housing is the solution to homelessness and that people should have choice over where they live and the choice to engage in services, as they deem appropriate. This helps to create housing stability and allows a person to truly transition from homelessness.

The impact of housing stability is enormous to the individual; it contributes to their physical and mental wellbeing and promotes independence.

During my exchange I met a man who had been street homeless for seventeen years, refusing to access shelter. He suffered with a severe and persistent mental illness and chronic alcoholism and other substance misuse issues. He moved into The Hegeman, a Common Ground building when it opened in 2011, and remained stably housed in summer 2014 with an up to date rent account. He accessed the accommodation on a Housing First basis as soon as he came off the street. He engaged with harm reduction alcohol and drug services until he felt ready to commit to detox. When we met he was clean and managing his mental health with appropriate treatment and was proud to show me around his home.

PSH provides sustainable housing to some of the most vulnerable US citizens and it does so while making cost savings against higher cost interventions. Ted Houghton, Executive Director of the Network, says PSH is recognised to reduce costs against emergency services, inpatient admissions and incarceration in the region of 40-60%. It is therefore highly regarded as a successful solution to homelessness, which has political backing. Its success evidenced by a further NY/NY agreement and a commitment from NYC Government to preserving existing stock and developing additional units.

PSH provides permanent affordable housing to a range of people with significant and complex needs. In the UK, it would benefit the most vulnerable people who are owed a full housing duty by their local authority and those who would meet the eligibility criteria for a supported housing placement.

Lessons could also be learned from the commitment to integration of populations. This helps to prevent the institutionalisation of those with experience of homelessness, mental ill-health and substance misuse issues. Each agency I visited cited long-term tenancy retention rates among their clients, thus reducing the damaging psychological impact of repeat episodes of homelessness.
References

1. NYC Department of Homelessness Services, 13/06/2014, Total Shelter Census 53,585 of which 10,317 are single adults
Mark Choonara
Stabilisation: helping people come home for good

Host: HomeStart
Location: Boston
The purpose of my placement with HomeStart in Boston through the Transatlantic Practice Exchange was to draw on their significant experience of providing ongoing support to people with experience of homelessness who have since been resettled into their own accommodation. Throughout the placement, there was a particular focus on the work they have undertaken through their Stabilisation programme, as well as their Housing First programme.

My interest in this area of work came about through the development of a new service at The Passage. As the UK's largest homelessness resource centre, The Passage offers a range of services, from street outreach to hostel services, from advice on housing and healthcare to support accessing training and employment. However, we had not previously offered a dedicated service to support clients once they were supported into their own accommodation. Home for Good is a new service designed to meet this need.

The idea for Home for Good came primarily from clients of The Passage, who had received support through our services and moved on to their own accommodation, but who found that transition particularly difficult. Many people reported isolation as one of the most difficult challenges to face, while others struggled with the pressures and responsibilities of running their own flat. In the early stages of consultation on the Home for Good project, one client summed up the situation with a memorable emotionally-charged request: "Don't leave me when I need you most."

Through being matched with HomeStart, the placement allowed me the opportunity to gain an insight into an organisation with an extraordinary track record of providing the type of ongoing, community-based service which we are striving to create through Home for Good. With a tenancy sustainability rate of 92% among clients of Housing First, and 96% in Stabilisation, HomeStart is clearly one of the leading organisations in this particular field. In preparing for the placement, the core research questions put forward were:

1. Which aspects of the ongoing support regarding tenancy sustainment and community integration have clients found most effective in the Stabilisation programme?
2. Which aspects of the Housing First programme can be identified as critical in supporting people to sustain their tenancies?
3. What commonalities are there between the ongoing support accessed through the Housing First and Stabilisation programmes run by HomeStart?

**Boston, Massachusetts**

To set the context for the work of HomeStart — and other organisations referred to here — I have to acknowledge that both the City of Boston and the Commonwealth of Massachusetts have invested significant resources into working towards ending homelessness. Having undertaken desk-based research prior to travelling, I was nonetheless taken aback by the range of homelessness and related services available in Boston, and the significant investment in these at both a city and state-wide level.

Massachusetts offers one of the most comprehensive arrays of homelessness service provision in the US, and is one of the leading states for its work in tackling this issue.

Within a few days of starting on the placement, I had realised that I would return to the UK not necessarily with an understanding of the American approach to homelessness, but more with an idea of the nature, scope and impact of the Massachusetts approach.

In contrast to homelessness services in London is the lack of requirement for a local connection in order to access accommodation and support. In London, and in many cities now across the UK, in order to have your homelessness application considered by a local authority you must demonstrate your housing, employment or family history in that particular borough. In Boston, services are open to all, regardless of city, state or even national connection.

It is also worth considering the role of shelters within the homelessness system. While acknowledging the principle of Housing First, that of supporting somebody to access their own accommodation directly from the street, it should be noted that many of the clients I spoke to had spent some time in the shelter system. Indeed, in looking at the numbers of people experiencing homelessness in US cities, and considering how highly populated the shelters are, it is important to explore the breakdown between those in this wider category, and those who are classed as unsheltered.

While Massachusetts does not guarantee the right to shelter for all, it is most certainly the cultural norm, with the expectation that anybody who wishes to access the dormitory-style accommodation in the shelters should be able to do so on any given night. This, of course, creates another level within the system, with far too many people seemingly stuck in this unsustainable accommodation, but it raises a number of difficult questions, and must be considered as a key factor in learning from the respective systems in place.

Yet another cultural difference is the understanding of the
term 'disabled'. Applied in a very different way than in the UK, the services I spent time with recognised a disability to be any disabling condition, including any physical or mental health issue. It is through this definition that most of the clients I met had been accepted onto their housing voucher, as without a disabling condition they would be very unlikely to access the accommodation and support services they now enjoy.

**HomeStart**

In addition to the Housing First and Stabilisation programmes, HomeStart offers a range of targeted services. Their Court Intervention Project (CIP) has been achieving impressive outcomes, not only in improving the lives of clients by preventing evictions, but also by evidencing the significant cost-saving implications of investing in prevention rather than cure. Their recent report on progress to date - An Ounce of Cure – demonstrates that on average their preventative work with families likely to otherwise be evicted can save $10,000 per case.

As the host organisation for my visit, HomeStart not only gave me a real insight into the services they themselves provide, but also arranged for a series of meetings and placements with other relevant organisations operating across the city and the state. This was invaluable for me to get a better and broader understanding of how systems operate both across the city and the state. It gave me a real insight into the Massachusetts network of services.

**Housing First and Stabilisation**

As summarised in the research questions outlined above, prior to the placement I expected much of my focus to be on the similarities and differences between the Housing First and Stabilisation models, and on how the strengths of each might be built upon. Within a few days of joining the HomeStart team, it became apparent that the differences between the two programmes were far fewer and smaller than expected. However, before detailing these similarities, it seems appropriate to explore a little more about each of the individual programmes.

A key issue to consider is the nature of client engagement on the Stabilisation programme. Whilst the nature of the relationship is flexible and personalised, engagement with their advocate is mandatory. As long as the client is accommodated on a HomeStart housing voucher, they are required to engage with support from the organisation. Failure to do so can result in them losing their voucher, and as such their accommodation. Having sat in on several initial interviews during my placement, I was impressed in both the way in which this was explained to clients, and their response. There was a distinctly professional approach to the situation, more so perhaps than we might expect in the UK, with the requirements explained and discussed as they would be in any commercial contract. Clients recognised the nature of the agreement, and workers treated clients as genuine equals and with a great deal of respect, reflecting the emphasis on customer service which I experienced in all aspects of American culture throughout the placement.

As well as speaking to a number of clients about their experiences on the programme, I was given access to raw data from a 2013 survey undertaken by the Stabilisation team which obtained feedback from 67 clients engaging with the programme. Access to this data provided a useful insight into wider client perception of both the programme and its impact. Evidencing the positive approach of the programme, 93% of respondents found their advocate respectful, and 90% found them helpful. 82% of respondents indicated that they saw their advocates often enough, which while impressive shows potential for further development in responding to need.

One of the most notable statistics I found in this data however, which has since had an impact on the development of the Home for Good project at The Passage, was that 90% of respondents confirmed that they knew their way around their neighbourhood. That this was asked in the survey, along with the very positive response, highlights the holistic nature of the programme in helping clients to settle into not only their new accommodation but their new community as well.

The Housing First movement that is currently receiving a great deal of attention both in the US and abroad, originated in New York in the 1990s. Working on the premise that entrenched rough sleepers required a stable base of their own before being expected to engage with any other support services, the organisation Pathways to Housing began helping people to move directly from the street into scattered site accommodation across the city. In time the service developed to offer assertive community treatment, but the premise of the client deciding which services to engage with (and which to not) remained constant.

HomeStart introduced this model of support to Boston in 2005, building on these strong foundations and enhancing the service through providing a version of their stabilisation support, only with a lower client - worker ratio to allow for more intensive working as appropriate.

Wherever possible, HomeStart also places an emphasis on helping people to access their own apartment, or scattered site Single Room Occupancy (SRO), unlike other projects which...
move people into single-site SROs. For the context of UK readers, it should be noted that some single-site SROs, whilst recognised as permanent supported housing, are incredibly similar to the homelessness hostels within our system. With shared cooking and bathroom facilities in a building full of other residents with previous experience of homelessness, the set up is very familiar, but is technically recognised as a permanent option for the resident, with move-on encouraged but not enforced, so long as the rent is paid. HomeStart’s focus on supporting people straight back into the wider community through a scattered site model is an important element of their wider focus on reintegration into society.

Another distinctive aspect of HomeStart’s Housing First team was the fierce focus on a team-based, rather than individual-based approach to working with this potentially difficult client group. From shadowing their work and from conversations with the team manager, it was felt that through building relationships between clients and the whole team, greater opportunities could be developed for each individual. In contrast, whilst the Stabilisation team were aware of one another’s clients, the focus seemed to be much more on advocates developing 1:1 relationships.

In addressing the similarities, both services provide personal, holistic, flexible support to individuals with experience of sleeping rough, and often with associated support needs such as physical or mental health, or a history of substance misuse. In both programmes, time is taken to develop a meaningful relationship between the advocate and the client. Regular meetings are held both at the client’s apartment and the HomeStart offices, and clients of both programmes are encouraged and supported to link into a wide range of relevant services, whether to address issues of substance misuse or to help them return to education.

Further, while Housing First is clearly targeted at people deemed to be more entrenched or chronic, with more complex support needs, a number of Stabilisation could just as easily have been referred onto Housing First instead, and vice versa.

Another key similarity across both programmes, which helps explain the extraordinarily high rate of tenancy sustainment, is the continuous effort to ensure each client does not return to the street, including arranging regular transfers as necessary.

In an important distinction from the UK system of housing benefit, the clients accommodated through a HomeStart housing voucher live in apartments which recognises the organisation, not just the individual, on the lease. This means that in the event of a likely forthcoming eviction, clients can be swapped between HomeStart properties, moved to different areas of the city (and occasionally, into the outer suburbs) in order to prevent a return to the street, and to provide another opportunity for a fresh start in a new neighbourhood.

While this may not be the most sustainable approach, and could draw criticism for failing to deal with the core issues of problematic behaviour, the reality is that it works in preventing individuals with complex support needs and a history of entrenched – or chronic – rough sleeping from returning to the streets. Such an approach would be far more difficult to orchestrate through the private rented sector, in which most former rough sleepers will now be accommodated in the UK, but it raises issues to consider within the social housing sector.

One of the most notable factors in both the Housing First and Stabilisation programmes was the restricted caseloads of key workers and advocates. While hard-and-fast limits were not in place, by aiming for Housing First workers to have no more than 12 active clients at any one time, and Stabilisation advocates no more than 25-30 (with a good number of these well settled and requiring only occasional meetings), there was an emphasis on developing and sustaining quality and effective working relationships. In comparing this to the caseloads of tenancy support (TST) workers in the UK, it is clear that the HomeStart model has recognised lower caseloads as a priority, and the benefits of such an approach can be seen in the exceptionally low rate of return to the streets.

With one of the primary objectives of the Transatlantic Practice Exchange being to disseminate learning across the homelessness sector in the UK, and to achieve positive change, this particular aspect is perhaps the easiest from which to provide clear recommendations.

The solution here is not overly complicated, nor something that is unachievable: caseloads must be capped.

The reforms introduced to tenancy support services over recent years, placing ever increasing caseloads onto workers, have meant that all too often the relationship between worker and client becomes little more than an occasional check-in or a response when a crisis is imminent or has already occurred. The HomeStart model demonstrates that investment in quality working relationships with clients - ensuring that they receive the time, attention and support from their worker that they require - is a highly effective model.

Rep Payee Service & Universal Credit

A service which will be of particular relevance to UK-based services in the near future is the rep payee scheme. Widely used across the sector, rep payees provide support to clients who have difficulty managing their budget, and can in many
cases access the clients bank account directly (with a series of checks and balances to protect against exploitation).

HomeStart’s model of support builds on this in offering a financial advice service to clients utilising their rep payee service. They not only help each client to spend their money better, but also help them to prepare a budget, set money aside for bigger planned expenses, and generally access personalised support through a key life skill that can easily be overlooked.

As the UK approaches the implementation of Universal Credit – an amalgamation of all benefits each individual is accessing (including housing benefit) in one regular monthly lump sum – there is a genuine need for services such as the rep payee and money management services in this country, not only in the homelessness sector but more broadly across welfare services that support a wide range of vulnerable and excluded people. Without the introduction of similar services, there is a chance that predictions of widespread evictions due to non-payment of rent following the roll-out of Universal Credit may become a sad reality.

Education, Aspiration and Employment

A visit to St Francis House, the largest day centre in New England, provided the opportunity to witness an incredibly progressive and effective employment preparation programme.

The Moving Ahead Programme, led by Joe Texeira, was an extraordinary example of people responding to the surroundings in which they are placed. MAP, funded by the Oak Foundation, is an intensive 14 week job and life skills training programme, students of which have histories of homelessness, addiction, mental health and imprisonment.

For the duration of the course, students are provided with dry accommodation, and are required to attend 9am – 3pm sessions every week day. The programme incorporates learning from the recovery sector, with students presenting their life stories to classmates early on, along with sessions on the application process, and even image consultations.

Of those who complete the programme (around 66%), an impressive 64% of students have found employment by the time of their graduation. A recently renovated shared office suite is freely available to any graduate of the programme to use, and the network of graduates appears strong. This focus on employment throughout all of the services I visited was clear and consistent, far more than in the UK. While there are many effective and impressive UK-based services designed to improve access to employment, getting a client registered on the appropriate welfare programme is too often seen as an outcome in itself, rather than simply as the beginning of their job-search process.

While it must be recognised that part of this drive to support clients into employment can be attributed to the more limited welfare system in place in the US, the idea that our clients are capable and deserving of paid employment is one which we would all benefit from introducing across the wider sector in the UK.

The Critical Role of Access to Healthcare

Perhaps the most obvious difference in public services between the UK and the US is in the area of healthcare. The lack of a national, universal, free at the point of access health system gave me a stark reminder of the overwhelming necessity of the National Health Service in the UK, and a timely reminder of the urgency of defending it.

As already highlighted above, Massachusetts is one of the most liberal and progressive states in the union with regards to healthcare. Despite the Affordable Care Act of 2010, commonly being referred to as ObamaCare, the federal initiative was developed based on the model introduced across Massachusetts in 2006 by then Governor Mitt Romney.

All of the clients I met had some access to healthcare. Even those without adequate access to healthcare were able to access services through some of the many initiatives in place across the city and the state, most often through the fantastic work of Boston Healthcare for the Homeless.

However, in speaking with one of the providers for a housing and healthcare service operating across the state, I came to realise the sheer complexity of the US-style system of competing health insurance companies (including those offering support through the MedicAid service) as well as the incredibly high costs of administering hundreds of competing services rather than a single, national service.

Through work over recent years in the UK we have made progress in bringing together homelessness services and healthcare; the recent hospital discharge projects across the country show the benefit to each individual of services working more closely together.

There is still much we can learn from the US system, including better access to detox and rehab services than clients enjoy in
the UK. However, we also have the opportunity to defend and protect a system that is central to the wellbeing of all of our clients, and as a sector we have an obligation to do so.

Shelters, Standards and Morality

A fundamental difference between the UK and the US is the use of the shelter system. In the UK we have invested in recent years in hostel programmes, and dormitory-style shelters now only appear in entirely non-commissioned services such as churches and other faith-based groups. In Boston the system continues to rely on these massive shelters to provide a place for those awaiting more appropriate and sustainable accommodation.

With the rise of Housing First as a model, there is a clear movement in the US to shift resources away from the shelter system and towards more effective long-term approaches to housing people straight from the streets. This is both understandable and commendable.

From a visit to one of the largest and most established shelters in the city, shelter conditions appeared to be somewhat chaotic and intimidating. Somebody new to the streets with no support needs would certainly struggle to adjust to the conditions there. However, despite these circumstances, the issue remains in the UK that many people are forced to continue to sleep rough whilst they await appropriate accommodation to become available.

This is unacceptable, and it was refreshing to witness the shocked reaction from workers in the Boston projects I visited when they heard that on the whole we in the UK do not operate shelters, nor provide any such emergency interim accommodation for many people who are sleeping rough.

This raised a question which has continued to resonate since returning from Boston: what if we're wrong about shelters?

From my experience of working with faith-based groups across Greater London, I’ve seen the beneficial impact of the winter night shelters operated on a voluntary basis by communities from churches, temples, synagogues and mosques.

With their more recent focus on linking with outreach teams, other established homelessness services, and a mission to link their clients into more stable accommodation before they close in the spring, some positive outcomes have been seen.

The shelter system I witnessed in the US has a focus on supporting clients not only into more sustainable and appropriate accommodation, but also the same holistic range of health, education and employment services to which day centres will often refer.

The issue of shelters is one I am eager to continue to explore. What we absolutely do not need in the UK is a lowering of accommodation standards. The danger of accepting a widespread shelter model is that it reduces the pressure for greater access to permanent housing, which is without doubt urgently needed.

There is an obvious danger of shelters attracting or keeping people in a certain area when it would be more beneficial for them to return to their borough, county or country of origin. A system would need to be designed in a way to prevent this otherwise likely negative impact. The model from the UK which springs to mind as a model for any potential UK shelter system is the Lambeth Assessment Centre4, which offers a few weeks of emergency accommodation access while new clients are supported to access more sustainable accommodation.

We must continue to work towards rolling out the type of Housing First model that is clearly working. However, until we can immediately accommodate people straight from the street, we should ensure that there is a place of safety available for them until suitable accommodation is being secured.

It was a meeting with a number of staff from the National Alliance to End Homelessness (NAEH) which produced a statement which I feel best encapsulated the role of shelters within the wider homelessness and housing systems: "they are a necessary last resort."

Next Steps

In applying my learning from the exchange to practice in the UK, The Passage has already started to develop the new Home for Good service some of the areas touched on above. In particular, the focus on supporting each client not only to settle into their new accommodation, but to reintegrate into their new community and wider society is central to the work of this programme.

This focus on supporting people to move beyond homelessness and into the community cannot be underestimated, and is essential in supporting each individual to realise and fulfil their potential.

It serves as a useful reminder of our shared goal: not of ending houselessness but homelessness; not of simply moving someone off the streets, but tackling the issues of exclusion, isolation and vulnerability to reduce the risk of them ever ending up in that situation again.

Improving our offer of support with securing employment will further help clients to establish and develop more active
networks and communities away from their former street lifestyle.

On the issue of building quality relationships, there is a strong case to be made for the effectiveness of capping caseloads, and there is the potential for a sector-wide campaign on securing real and meaningful tenancy support, rather than the crisis-response model we appear to have shifted towards in the UK over recent years.

There is scope to build such a campaign on a save-to-spend model, arguing that greater investment in prevention of repeat homelessness is a more cost effective alternative across the range of public services than allowing somebody to return to the streets, and in doing so be more likely to utilise the higher-cost emergency services which people sleeping rough will often tend to access.

The homelessness sector should take on the role of standing up and opposing further damage to the cherished institution that is the National Health Service. This need not be a political campaign in the sense of protesting or supporting any particular party, but part of the wider public service campaign to protect an institution which provides so much support to our clients and which is currently under real threat. Having spent the exchange in perhaps the most progressive state in the US when it comes to healthcare, the complexity and extraordinary administration cost of the insurance systems in place in the US would likely mean that our clients would face a significant reduction in their access to healthcare under reforms to further privatise the NHS.

Finally, this exchange has raised awareness of the very real potential for greater international lesson sharing across the homelessness sector, and will hopefully act as a catalyst for further and more widespread opportunities to share innovative ideas in helping to end homelessness.

From my own experience, I returned to the UK proud of the areas in which we’re leading, and both angry about and inspired to work harder on the areas in which we’ve fallen behind.

I certainly intend to keep in contact with many of the people I met in Boston in order to share updates on how our respective programmes are working and to explore ideas for future potential collaboration. In drawing on those who are making strides towards ending homelessness in other countries, we can only strengthen our own efforts to end homelessness for good in the UK.

References

2. http://www.stfrancishouse.org/site/PageServer?pagename=Programs_Vocational_MAP

Useful Resources

- www.bhchp.org
- www.eliotchs.org
- www.friendshipplacedc.org
- www.homeless.org.uk
- www.homestart.org
- www.hud.gov
- www.mhsa.net
- www.naeh.org
- www.passage.org.uk
- www.pathwaystohousing.org
- www.pinestreetinn.org
- www.ppffound.org
- www.stfrancishouse.org
David Orton
Permanent Supportive Housing for people over 50

Host: Hearth
Location: Boston
Homelessness among older people in England is a growing problem. In the year leading up to March 2014, 635 people aged over 55 slept rough in London. This number has significantly increased, up 9% from 2013 and 53% from 2012.

Yet the issue of older homelessness receives relatively little focus in the UK and few services target this population. The Older Homeless Partnership Programme, which funded projects for this group, and the UK Coalition on Older Homelessness, which campaigned and advocated on the issue, disbanded in 2002 and 2010 respectively.

In my own experiences of working in the homelessness sector, older people exist in the gaps between homeless and mainstream elderly services, with neither adequately addressing their specific needs. Many older rough sleepers feel alienated from homeless provision designed for a younger cohort. Some I’ve worked with have been reluctant to enter hostels because they feel vulnerable in such environments, even when sleeping on the streets is exacerbating serious health conditions.

There is also a distinct lack of satisfactory move-on options for older people living in hostels. Programmes which resettle homeless people into the community, such as Clearing House, generally do not provide accommodation which meets the physical needs of older people or support which addresses problems such as declining cognitive function and social isolation. Conversely, housing options for the generic older population, such as Sheltered Accommodation or Extra Care schemes, are usually unwilling to house someone with significant mental health or substance misuse issues. This can create great barriers to finding suitable accommodation for older homeless people, as these are support needs experienced by 58% and 46% of those aged over 55.

Exchange aims and context

Against this backdrop, the Transatlantic Practice Exchange was an excellent opportunity to examine how services could be better designed to serve older homeless people. I aimed to test my hypothesis that permanent supportive housing (also known as service-enriched housing) can bridge the gap between the support needs of the homeless and the health issues of the aging. I wanted to examine whether in doing so it can create a stable environment which is more inclusive and less isolating for older people.

My host, Hearth Inc, is a Boston-based organisation which works to end homelessness among people aged over 50. The organisation has a three-pronged approach to reaching this goal. Firstly, they have seven housing residences in the city, 188 units in total, which provide permanent accommodation for those who are homeless or at risk of homelessness. Secondly, Hearth’s outreach team works to find appropriate secure accommodation for homeless over 50s and provides a six-month stabilisation service to ensure they maintain these tenancies. Finally, the organisation conducts research and advocacy to increase awareness of the issue of elder homelessness. This aspect of their work has a wider geographical scope and they work to instigate changes in policy and funding at a city, state and national level.

Hearth’s work takes place in the context of growing rates of elder homelessness in the United States. In 2010, 44% of people in homeless shelters were aged over 50, compared to 23% in 1990.

The increasing age of homeless people in the US far exceeds the rate of aging in the general population. This has been attributed to a cohort effect, in which those born in the latter stages of the baby boom had their prime years disrupted by the 1980s recession, leading to fragile economic prospects. This particular cohort has been characterised by high levels of homelessness throughout the last three decades and the problem continues to follow them as they approach old age.

Despite the scale of the problem, there are still relatively few organisations concentrating their efforts on eliminating older homelessness and the issue has not been high on the policy agenda. Funding from the Department of Housing and Urban Development has tended to focus on initiatives which promote self-sufficiency and employability, incongruent with the abilities of many older people. This, combined with a far less universal system of welfare than in the UK, means that demand for all Hearth’s services is high. This report specifically focuses on my experiences of the permanent supportive housing programmes. However, my placement also provided an eye-opening insight into Hearth’s outreach service and I was struck by what a vital lifeline this is for so many in the Boston area.

The scale of elder homelessness in Boston far outstrips capacity in Hearth’s accommodation, so commonly the outreach case-managers navigate the complex processes involved in obtaining affordable accommodation through other means.

Last year, the team of five successfully housed 148 people who were desperate to find a way off the city’s streets and out of its shelters. To do so, they must overcome the great barriers to accessing subsidised housing, such as the strict criteria which can proscribe those with criminal histories, substance misuse issues or previous evictions. Wherever possible, Hearth pulls down these barriers for its own accommodation, which is the first step in creating housing suitable for older people who have experienced homelessness.
Hearth Housing

All of Hearth’s housing programmes have an on-site multi-disciplinary team, providing coordinated wrap-around support for tenants. This includes a fully qualified social worker, a site director, a registered nurse and a personal care homemaker. The latter assists those residents who need it, with Activities of Daily Living, such as washing and dressing.

Hearth employs a blended funding model to finance this network of support. 56% of the residents have a diagnosed mental health condition and Hearth acts as sub-contractor for a Department of Mental Health initiative to provide case management and clinical support.

People who need assistance with daily activities due to immobility or cognitive impairments are registered with a programme financed by Massachusetts’s Medicaid system, which contributes to the cost of the homemakers and nurses. This is combined with small amounts of funding from Boston’s elderly commission and some innovative fundraising, such as the adopt-a-room campaign at Hearth’s newest residence.

Supporters who donated money to purchase the furnishings at Olmsted Green (which meant the units were fully fitted for those with few possessions) were encouraged to help assemble that particular apartment and add their own touches. This initiative provoked a hugely positive response and has resulted in each apartment possessing its own unique character.

Physical Health and Mobility

These are key considerations, since homeless people in the US experience geriatric conditions such as falls and memory loss 15-20 years earlier than the general population6.

Hearth’s housing is accessible and certain apartments are fitted with features such as shower seats and grab bars in the bathrooms. The overarching principle is that people should be allowed to ‘age in place’ without the risk that any deterioration will force them to leave their home. Some individuals reported they had been living in Hearth’s housing for over a decade, despite previously having been homeless for many years more than that. Their rooms were always reserved for them, even during lengthy stays in hospital or periods in detox, which meant they did not have to choose between being healthy and being housed.

As many of the tenants are experiencing the physical and psychological deterioration associated with age and in some cases also serious illnesses, there is a heavy focus on promoting wellness. Many were very poorly connected to health services when homeless, only ever receiving medical attention in Emergency Rooms when their condition became extremely acute. It’s not uncommon for new arrivals to have severe untreated or even undiagnosed illnesses. The on-site nurses build strong relationships with external health professionals, such as primary care physicians, producing a coordinated response in which the care and support that residents receive at home is carefully targeted at producing the best possible health outcomes.

Stabilising the health of a formerly homeless individual is not always a simple process; often it involves the staff gradually instilling feelings of self-worth and a desire for self-care, whilst also establishing trust in the professionals many have been alienated from whilst homeless. In the larger sites, the nurses run coffee mornings in which informal discussions around health and wellbeing aim to plant the first seeds of change in people’s mindset.

Hearth have successfully recruited a small army of volunteers to run an array of other activities to help keep residents healthy and well, such as graduates in physiotherapy or nutrition, who run exercise classes and healthy eating lessons.

Cognitive Impairment and Memory Loss

Hearth’s experience of working with cognitive impairment and memory loss means they have developed effective methods for assisting this population. They understand what kind of support they require, how information is best verbally conveyed and what other techniques can be employed, such as creating written schedules for self-care or using colour coded cards to remind residents which medication to take. It also informs their expectations of the tenants; deteriorating cognitive function, combined with declining physical health, means many can’t feasibly achieve the objectives dictated by mainstream homelessness services, such as becoming ready to live in a fully independent setting.

It can be challenging to calibrate these realistic expectations with funding streams traditionally aimed at a younger age group. Such is the case with the Department of Mental Health programme, which requires subcontractors to focus on teaching clients new skills which will help prepare them for entering employment.

The staff demonstrated they consistently focus on residents’ skills, but in some cases this will be ‘re-learning’ something they’ve forgotten, learning a new method to complete a task which they’d lost the ability to do, or simply learning something which will keep them safe, such as fall prevention.
To the outside observer this may not present as ‘progress’, but without this work it’s certain that the tenants would be less independent and less well.

**Substance Misuse and Mental Health**

The social workers case manage those with mental health or substance misuse needs, but all staff have a superior knowledge in these areas than is reported in mainstream elderly services. This has created a culture which understands the behaviours these issues can produce and in turn, a coordinated effort to remedy them in a non-punitve manner. Substance misuse is recognised often as a mechanism for dealing with emotional traumas and it’s accepted that recovery won’t be achieved without a psychologically informed approach.

All of Hearth’s accommodation and outreach staff are currently undertaking ‘Screening, Brief Intervention and Referral to Treatment’ training. SBIRT is a method for identifying those with problematic substance use then increasing their insight and motivation to change. It has its foundations in motivational interviewing techniques, the aim being to build on a long history of supporting people into detox programmes and through ongoing recovery. Motivational interviewing was also said to be a fruitful way to build trust and rapport with older people, as it puts them in charge of their own destiny at a time of life when many start losing control of decisions which affect them.

The social workers conduct intensive work with those tenants who have mental health issues, meeting with them at least weekly for care planning and clinical support. Care plans incorporate goals which can cover aspirations in all areas of life, but particular attention is paid to individuals gaining better insight and control of their mental health. Medication adherence plays a key role, but there is also impressive work on reducing symptoms through cognitive-behavioural techniques and psychological strategies such as mindfulness. Due to age related memory issues, this support will often require consistent ongoing repetition to help residents retain such information. One social worker reported when this is not successful, actively guiding residents through these techniques during episodes of hallucination.

**Independence and Social Isolation**

Without Hearth’s housing many would be living in nursing homes in which their freedoms would be significantly curtailed. Instead, the residences individually adapt their support and develop various initiatives to provide each tenant with the most independence and autonomy possible. Hearth has a volunteer representative payee overseeing the finances of those who a physician has judged to not be capable of doing so, preventing them from becoming homeless again through rent arrears or other debts. Minimum balance and transfer requirements mean those on low incomes often struggle to open and retain a bank account in the US. The rep payee has built a partnership with a local bank which bypasses these criteria, meaning tenants can enjoy the freedom of withdrawing their disposable income at an ATM.

At Olmsted Green, every week the ‘Fresh Truck’ parks up in their car park and serves as a temporary shop (which also accepts food stamps) to enable those without the mobility to reach a supermarket to retain the independence of shopping for their own food. The staff also connect tenants with programmes which provide transport for those not mobile enough to use the public transit system, meaning they stay well connected with the community and able to participate in activities outside of their home.

Keeping people connected with the community is one aspect of Hearth’s work to stave off social isolation. As we age, we become more prone to isolation due to narrowing social networks and declining mobility, but a history of homelessness can further heighten the chances of this occurring.

One tenant reported he had lost contact with all his friends and family during decades in shelters and on the streets. Therefore, preventing loneliness and social isolation is a focus of the permanent supportive housing model for elders. All the residences have large amounts of communal space, including lounges, dining areas, activity rooms, libraries and in the newest centre, a fitness room with wheelchair accessible equipment.

New arrivals can sometimes be reluctant to socialise with other residents, especially those with negative experiences at homeless shelters who associate communal living with aggression and theft. To remedy this there is an eclectic programme of activities aimed at engaging the tenants. The staff team also lead by example, often dining with residents and sparking conversations between them.

The sites have far from an authoritarian feel, but there are certain rules designed to bring people together, such as prohibiting the same television programme being watched in two different lounges.

Many tenants were extremely enthusiastic about the social aspect of PSH. One man said his years of homelessness had been prolonged as he didn’t want to move to an apartment where he’d be lonely and referred to a fear of dying alone. He was grateful to have found a place that offered both...
independence and the company of others, which was happy to accept him despite his problems.

Outcomes

In the US, there is a steadily growing consensus that permanent supportive housing is an effective and much needed approach to ending older homelessness. Housing of a similar mould to Hearth’s now exists in cities including Los Angeles, Minneapolis and Columbus. The successes of the model are self evident. I was impressed by the length of time that people remained in their home at Hearth, even those with very complex needs. The residences were stable, supportive environments where people, many of whom have experienced much trauma in their lives, can enjoy the remainder of their life knowing that the staff will do everything they can to keep them healthy, well connected and most importantly, housed.

Data is emerging which supports these anecdotal observations, illustrating the effectiveness of permanent supportive housing for the older homeless population and the resulting cost savings.

Analysis of residential schemes for homeless veterans aged over 55 found that those placed in a permanent supportive housing site cost the state $7,500 less a year in health, mental health and substance misuse services than those placed in other residential sites. Cost efficiency is also demonstrated in a study of a PSH scheme for homeless seniors in San Francisco, which saved $9.2 million from the public health bill in a study of a PSH scheme for homeless seniors in San Francisco, which saved $9.2 million from the public health bill in the seven years it has been open, $700,000 more than its total operating costs. Research into outcomes after a year at another PSH scheme in Charlotte identified significant decreases in emergency room visits and arrests, whilst tenants’ income markedly increased during the same period.

Applying Learning to England

It’s clear that the permanent supportive housing model could better meet the needs of many older homeless people than the provision which currently exists in England. Hearth and other US providers have demonstrated that the major components of such services can be financed by combining existing public funding available for housing, health, mental health and the older people. This is a possibility which merits further investigation from UK homelessness agencies, yet is likely to be more challenging in our system which is heavily dependent on the rigid framework of local authority commissioning.

One solution is a more flexible and creative approach from local authorities, including partnership working between commissioners of homelessness and older person services to create provision which fills the void between them.

For those commissioning housing and support for people who are homeless, this will require a shift in the narrowly defined definitions of what constitutes successful outcomes, with an acceptance that resettlement into independent accommodation and participation in employment are unlikely to be achieved. Some benefits of PSH, such as reducing social isolation, may be judged to not be sufficiently tangible, so it’s vital to emphasise the positive health effects of the model.

The savings associated with minimising older homeless individuals’ use of emergency care and long-stay hospitalisation over a number of years should be demonstrated to bodies such as Clinical Commissioning Groups. If this message is effectively conveyed, I’m hopeful NHS funding could contribute to establishing such services at a time of severe pressure on local authority budgets.

If these long-term health benefits are to be felt in the UK as they are in the US, it’s vital that the principle of aging in place is retained. Again, this requires a marked shift from the prevailing attitude that congregate homelessness accommodation provides only a stop-gap before resettlement. There is a handful of residential care schemes in the UK run by established homelessness providers and a minority of extra care housing projects will accept those with problematic substance misuse. Although these are valuable resources where available, what is needed are services which appropriately house homeless people at the start of their journey into old age, meaning they remain more independent and healthy for longer.

Such systemic changes in the practices of statutory bodies are unlikely to occur without significant advocacy from the voluntary sector. I plan to disseminate the learnings in this report and other findings from my placement at Hearth, such as the undoubted success of outreach and prevention services aimed specifically at the elder homeless, amongst housing/homelessness agencies and older person organisations. My hope is to contribute towards a consensus that neither side is successfully meeting the needs of all those facing homelessness in the later stages of their life, prompting greater collaboration in the drive for change.

The implementation of permanent supportive housing is an ambitious goal. However, greater partnership working between third-sector bodies in both fields could still have a hugely positive impact on existing services. The exchange has given me a great insight into the areas of knowledge and practice which could benefit from being informed by the work of agencies with a greater focus on the elderly. In the project in which I work, a 38-bed hostel in which 13 of the clients are...
considered ‘high support elders’, I will forge stronger links with such voluntary and public sector agencies. Through this, I hope to improve the effectiveness of our approaches in working with those experiencing issues such as cognitive impairment, social isolation or declining mobility, but also our awareness of the wealth of services available to older people through mainstream agencies.

My goal is that as we work towards housing and support which is better designed for homeless older people from the outset, we can still personalise current provision to better meet their needs and subsequently reduce the alienation of elders from homelessness services.

Conclusion

As the population in England continues to age, it’s likely the number of older people who are homeless or living in unsuitable accommodation will also grow.

My experiences on the transatlantic exchange have convinced me it’s vital that permanent supportive housing forms part of our response to this problem. It is an all-encompassing solution which combines the acceptance and expertise around issues such as mental health and substance misuse already found in our homelessness services, with high quality support for health conditions which affect us all as we age but that occur earlier and are more acute in those who’ve experienced homelessness.

It also gives careful consideration to how independence can be maintained and social isolation reduced in the face of these difficulties. While facilities and services play an important role in the success of permanent supportive housing, it can also in part be attributed to the practices of the staff that have greater experience of working with the older client group. Therefore, there is no reason why approaches in existing provision in England cannot also be modified to better meet the needs of older homeless people.

References

2. Clearing House takes referrals of those who have at one time slept rough in London and if suitable allocates them a tenancy in a Rough Sleepers Initiative property provided by a range of RSLs in the city. Once in the accommodation, the individual is given support by the Tenancy Sustainment Team to maintain their tenancy and move on once ready.
8. M. Lori Thomas, Jeffrey Shears, Melannie Clapsadi Pate, Mary Ann Priester. Moore Place Permanent Supportive Housing Evaluation Study, University of North Carolina: 2014
Adrienne Breidenstine
Hospital Discharge Strategies

Host: Justlife
Location: Brighton
It is well known that people experiencing homelessness have poor health outcomes and are at increased risk for premature mortality. Because living on the streets creates new health problems, exacerbates existing ones, and makes adhering to medical care plans more difficult, individuals and families experiencing homelessness are three to four times more likely to die prematurely than their housed counterparts.

In addition to poor health, people experiencing homelessness have frequent emergency department visits and inpatient hospital stays. Nationwide, the average hospital stay for most patients is 4.6 days, but homeless patients average a stay of nearly twice as long. Costs associated with longer hospital stays can be substantial for hospitals and the overall health care system.

There is no consistent model or best practice in the United States for hospital admission and discharge of people experiencing homelessness. Consequently, homeless patients are frequently discharged from the hospital to the streets or to shelters with care instructions that are difficult to follow in these living situations. Without a safe, medically appropriate place to recover, homeless patients’ health is further compromised, which exacerbates health problems and often results in readmissions to the hospital.

Across the Pond

In England, the intersection between health and homelessness is similar to the United States: there are significant health disparities between people experiencing homelessness and those in the general population. Homelessness is considered an independent risk factor for premature mortality, as the average life expectancy of homeless persons is just 47 years. People experiencing homelessness are frequent users of Accident and Emergency (A&E), the emergency department, and the annual cost of this unscheduled care is eight times that of the housed population.

Addressing health disparities for vulnerable populations recently became a national priority for England. The Health and Social Care Act of 2012 imposes for the first time a statutory obligation for all health care providers to "have regard to the need to reduce health inequalities" through the services they provide.

Local health departments in communities implement health care delivery models that address the unique health care needs of people experiencing homelessness. In Brighton, practices addressed inequities but also helped to spur the expansion of hospital discharge models in communities throughout England.

Learning Objectives for Exchange Placement

During my Transatlantic Practice Exchange placement, I examined the hospital admission and discharge model for homeless patients in Brighton, England and the impact this model has on health outcomes and hospital readmissions of homeless patients. Learning objectives for the placement included:

1. Explore the environmental factors and planning process used to develop hospital admission and discharge practices for homeless patients
2. Analyze hospital admission and discharge practices for homeless patients
3. Examine post-hospital care programs/models for people experiencing homelessness
4. Evaluate hospital and post-hospital program outcomes for discharged homeless patients

Exchange placement: Brighton, England

Known as "London by the sea," Brighton has almost a quarter of a million residents and is an attractive tourist destination. Because of its close proximity to London, it feels the pressures of high property prices and pockets of poor quality housing, both of which have a detrimental effect on the health and well-being of many residents, particularly people experiencing homelessness. High market rents, health inequities, and inadequate social supports contribute to the high levels of homelessness.

Brighton has the third largest homeless population in England with nearly 10,000 households living in emergency accommodation. Emergency accommodation is housing provided by the Brighton and Hove City Council that operates as transitional living for someone until a permanent housing situation is found. According to Brighton and Hove City Council, from 2001-2007, the number of people rough sleeping (street homeless) on any one night decreased from 66 to 12. This is perceived as an undercount because people experiencing homelessness are difficult to count and it only counts people who are living on the streets on one night.

Learning

Pathway Plus is a hospital admission and discharge pilot partnership among Brighton and Sussex University Hospital Pathway Hospital Team, St John Ambulance, Brighton Homeless Healthcare, and Justlife. This pilot partnership was launched in October 2013. The roles of the Pathway Plus partners are:

- Hospital Pathway Team is a team of medical providers,
including a General Practitioner (GP or primary care physician) and nurse practitioner who work with homeless patients admitted to the hospital for an emergency or inpatient admission.

- **St John Ambulance** provides non-emergency patient transport to people experiencing homelessness. When homeless patients are discharged from the hospital, St John Ambulance transports them to their destination and also is available to transport patients to after care appointments.

- **Brighton Homeless Healthcare** is a health care clinic serving people experiencing homelessness. The clinic provides primary medical care services, including physical examinations, treatment for chronic health conditions, and certain types of acute care for an illness or injury. When homeless patients are discharged from the hospital, they are connected to Brighton Homeless Healthcare for after care.

- **Justlife Brighton** is a charity organization that provides support to homeless patients who live in emergency accommodation after they are discharged from hospital. Justlife ensures that clients' health recovery is sustained by providing non-clinical support to patients that includes connecting them to public benefits and appropriate support services available in the city.

The Pathway Plus staffing model is a team of clinical and non-clinical staff that works with homeless patients while in hospital and post-discharge.

- One GP at 4 sessions per week based at the hospital
- One full time nurse practitioner based at the hospital
- One part time community nurse from Brighton Homeless Healthcare
- Two full time, non-clinical floating support workers from Justlife
- One full time advocacy worker/patient co-ordinator from St John Ambulance
- One part time project manager from Justlife

**Pathway Plus Working Model**

The Pathway Plus Working Model is designed to ensure that homeless patients discharged from the hospital are connected to appropriate after care services and support. The model includes the following key components:

- Discharge planning begins at the point of admission, as the Hospital Pathway Team begins coordinating patients' care with Justlife to identify emergency accommodation and appropriate community supports. The Team also coordinates with St John Ambulance to ensure that the patient has suitable accommodation and medical transportation on the day of their discharge from the hospital. The Pathway Team provides medical treatment and care to homeless patients until they are considered "safe for discharge," meaning that the patient has a medically appropriate place to go upon discharge from the hospital.

Although "safe discharge" is the focus, it is not uncommon for the Pathway Team to discharge homeless patients when they are considered "medically fit," meaning it is not medically necessary for the patient to remain in the hospital. In these cases, patients are often discharged to the streets, in which case the Pathway Team will contact Brighton's Rough Sleepers Team (outreach workers) to inform them of the patient's discharge status. Pressures to get patients out of the hospital as quickly as possible and the need for hospital beds compromise the Pathway Team's practice of "safe for discharge."

Upon discharge from the hospital, Justlife coordinates post-hospital medical care and ensures that the patient gets connected to public benefits and community support services, such as addiction treatment or counseling.

Patients are referred to Brighton Homeless Healthcare for post-hospital care, and in most cases, Justlife support workers will accompany patients to their follow up appointments. Justlife and Brighton Homeless Healthcare are in constant communication to ensure that patients' health care and community support services are well coordinated. Follow up health care, community support services, and access to benefits are important to ensure housing retention and reduce readmissions to the hospital.
Case study: John's experience with Pathway Plus

John came to Pathway Plus / Justlife after a number of suicide attempts, some of which resulted in hospitalization. John suffers from alcohol addiction and suicidal ideation. Justlife workers supported John throughout his addiction treatment. He now attends recovery groups and reduced his drinking from a bottle of vodka a day to just two cans of lager. Since engaging with Justlife, John has not had any hospital admissions and has not suffered from suicidal ideation. John describes his experience with Justlife as "inspirational and encouraging."

Pathway Plus Outcomes

After several months of implementation, preliminary results show that clients served by Pathway Plus were connected to appropriate post-hospital care and reduced use of emergency services, including ambulance and A & E. From October 7, 2013 through December 13, 2014 the Hospital Pathway Team identified 60 homeless patients; however, just 20 patients were discharged to emergency accommodation (EA). Of the 20 clients in EA, 19 registered with a GP after their engagement with Pathway Plus. These 20 clients also saw a significant reduction in ambulance and A & E use after engagement with Pathway Plus. The entire cohort of clients was admitted to A & E 57 times before entering Pathway Plus. This was reduced to 12 times after their engagement during the same reporting period.

Local Practices

1. Engage hospitals in design and development of coordinated intake and assessment.
A coordinated access and assessment system is intended to streamline access to homeless services and target resources to the most vulnerable individuals and families experiencing homelessness. As communities begin the planning process for coordinated intake and assessment, it will be important to ensure that key stakeholders provide input into the development of this system. Hospitals are important partners to be included on a planning committee and potentially throughout the design and development phase of a coordinated intake and assessment system. Given that many people experiencing homelessness are frequent users of emergency departments, there is an opportunity to use the hospital discharge process to connect homeless patients to services through the coordinated intake system.

2. Identify long-term solutions for reducing unnecessary or avoidable hospitalizations for people experiencing homelessness.
Homeless people who are frequent users of emergency departments and inpatient hospitalizations represent a significant opportunity for cost-savings to hospitals and the health care system. One such initiative that has been implemented in several communities is the Frequent Users Services Engagement (FUSE) model. This model increases housing stability and reduces hospital and service use, resulting in public cost offsets. Communities are encouraged to examine their local context and need to develop systems collaborations to target housing and support services to people experiencing homelessness who are frequent users.

Practice and Policy Implications

There are many differences and also many similarities between the health care systems in the United Kingdom and the United States. For example, both countries are struggling with increasing costs of care; both are implementing initiatives and programs to improve the quality of care and address health disparities; and both have instituted health care reforms that change the structure of how care is delivered. The United Kingdom has a national health service, in which every person is covered as a matter of right. The UK system uses a single-payer financing mechanism, meaning everyone pays into the system and everyone receives care. However, the United States health care system is a mix of private and public health insurance options. Health reform meant to insure more people but millions still do not have health insurance, which contributes to increasing health care costs in America. Due to the differences in the ways that the UK and the US finance and deliver health care, it is not likely that the Pathway Plus model could be replicated in the US.

National Policy Recommendations

1. All states should fully expand Medicaid.
The Affordable Care Act (ACA) presents new opportunities for communities to improve health outcomes for people experiencing homelessness, many of whom are uninsured. The option states have to expand Medicaid to cover non-disabled adults who earn at or below 138% of the Federal Poverty Level presents the most significant opportunity to improve health care coverage and enables access to a wider range of health services for people experiencing homelessness. Currently, only 27 states and the District of Columbia are implementing Medicaid expansion. Medicaid expansion also provides states the flexibility to finance additional health services for special populations, including homeless populations, through
state options such as 1115 waivers and the Health Homes for enrollees with chronic conditions. States that pursue these options have created health service delivery models to finance services in supportive housing, like outreach and engagement and general case management.

2. Identify Department of Health and Human Services (HHS) funding for community supports, such as case management, care coordination, and peer supports. Health Center grants, SAMHSA block grants, Ryan White, PATH, and other HHS programs must remain available as the safety net for the millions of people who will remain uninsured under the ACA, and to help fill the gaps in community supports. Community support services are essential to help clients to transition to becoming more self-sufficient and achieve long-term stability. HHS should examine opportunities for improving care transitions for people experiencing homelessness and invest in the resources to carry out effective programs for this population, including transportation to follow up visits and care management or case management.

3. Identify consistent funding mechanism for Medical Respite. Medical respite is short-term post-hospital residential care for homeless people who are too ill to recover on the streets, but are not ill enough to remain in a hospital. Medical respite serves as an alternative to discharging homeless patients to the streets so that they can continue hospital-recommended care and fully recover. Studies find that homeless patients discharged to a medical respite program experienced 50 percent fewer hospital readmissions at both 90 days and 12 months of being discharged compared to patients discharged to their own care. Health reform provides opportunities for health care providers to implement innovative health models, including discharge planning programs, at hospitals. However, a consistent funding mechanism for medical respite has not yet been identified. HHS should identify additional funding opportunities to pay for medical respite care, such as the Health Center program.

References

4. The Faculty for Homeless and Inclusion Health, Standards for commissioners and service providers, Version 2.0, September 2013
5. Brighton & Hove Homelessness Strategy, 2008-2013
6. Because Pathway Plus is partially supported by the Brighton and Hove City Council, Justlife only serves patients that are discharged to temporary accommodation. Other community providers serve patients who are discharged to hostels, housing options, or the streets.
7. Corporation for Supportive Housing, Blueprint for FUSE
8. 138% of the Federal Poverty Level equates to approximately $16,000 a year for an individual and almost $27,000 for a family of three
11. National Health Care for the Homeless Council, Medical Respite Care: Reducing Costs and Improving Care, April 2011

About Adrienne Breidenstine
Adrienne works for The Journey Home - Baltimore, MD.
Aubrey Patiño
Chronically Excluded Adults: the MEAM Approach

Host: Cambridgeshire County Council
Location: Cambridge
My practice area of focus was the population defined in the UK as having "complex needs" and those they refer to as "chronically excluded adults" (CEA). The complex needs/CEA population tends to be those who touch multiple systems, but are not being adequately served by all of them despite the broad range of interventions. Many have complex trauma histories, which are often further exacerbated by the experience of homelessness. Most have a history of chronic homelessness. There is a high rate of co- and tri-morbidity among this population, with complex physical and behavioral health issues. They are the victims of silo-based interventions where there is failure to adequately communicate and allocate resources across silos to effectively meet an individual's needs.

Homelessness in the UK is measured in different ways than in the US. The UK does not have a national database tracking data such as the Homeless Management Information System. When I asked how many people are experiencing homelessness in Cambridge (population 123,900) on any given night, I was told that their data indicated nine. However, their temporary accommodations and streets told a different story. They only measure those who are "rough sleeping" (defined as unsheltered and literally homeless) and "bedding down" (setting up their sleeping arrangements) at the time they are counted. This has huge implications for data quality as it excludes masses of people who are staying in shelters, in housing that functions similarly to transitional housing in the US, or are on the streets but not "bedding down." It presents an inherent struggle in their ability to manage the issue, since they lack sufficient knowledge about the scale of the problem.

The most significant difference between the paths to ending homelessness in the UK and the US is the emphasis on temporary versus permanent solutions. The UK emphasizes ending "rough sleeping" i.e. getting individuals off the streets (literally). The US emphasizes ending "homelessness" i.e. getting people housed. Housing First, the principle of moving people directly into housing off the streets without preconditions of treatment acceptance or compliance, has not been widely implemented in the UK. In the US, we have defunded shelters and transitional housing. In the UK, "temporary accommodations" or "hostels" are seen as the solution to preparing someone for their own tenancy. Temporary accommodations or hostels may encompass everything from a short term stay to a two year service intensive placement. As a result, it is evident that there are simply fewer people sleeping outside in the UK.

Legal mandates such as the "duty to accommodate" (which requires the government to accommodate someone who is homeless and meets certain criteria) and an initiative titled "No Second Night Out" (implemented to prevent anyone from sleeping out for more than one night before they are offered a rapid response) are indicative of a cultural expectation that the public sector is responsible for addressing this issue. The US has made greater strides in offering permanent solutions by its emphasis on Housing First and permanent supportive housing. However, the US also has masses of people sleeping on the streets or "literally homeless" as defined by the Department of Housing and Urban Development (HUD). This experience led me to believe that there is a higher degree of tolerance for homelessness and acceptance of this reality as a social norm in the US than in the UK.

In terms of population specificity I saw more in common than not with the chronically excluded adult population and the chronically homeless single adult population in the UK and US, respectively. The common ground was complex physical and behavioral health issues, multiple providers involved in one individual's care requiring good systems navigators to communicate across systems, and co-occurring disordered individuals suffering a greater disparity in care than others. In both countries, it is known that this smaller subset of the population is much costlier to the community than the vast majority of episodically homeless individuals.

The major difference I saw with this population was their access to primary care. Primary care access for the indigent population I witnessed in the UK was astounding. The two general practices I shadowed were multi-service agencies providing drug and alcohol treatment, opiate replacement therapy, mental health services, and peer supports, all under one roof. All care was linked to and from primary care.

Learning

During my exchange I explored the work of the Making Every Adult Matter (MEAM) approach in Cambridgeshire. The MEAM approach is a pilot demonstration initiated in a few different communities across the UK that strives to establish a new model to serve what they call the chronically excluded adult population. The Chronically Excluded Adult (CEA) team coupled with the Single Adult Service in Cambridgeshire served as my host program. The CEA team works to serve as the primary systems navigator for the client by wrapping care around them and communicating across providers, and in turn, they reduce public sector costs and improve quality of life outcomes. Their collaboration across sectors serves not only as an opportunity for continuity of care but as an opportunity for providers to learn and grow from one another’s expertise and hold each other equally accountable for the wrap around services being provided. The Single Adult Service focuses their work on individuals with lower acuity whose main barrier to stability is primarily housing. The Single Adult Service works...
to help individuals establish housing placement and to link people to and coordinate services as needed. The two teams work together and cross serve populations as needed.

The MEAM approach is working in Cambridgeshire and they are seen as a flagship model nationally. They demonstrate service that is person-centered while constantly prioritizing the self-identified needs of the individual they are serving. Rapport-building is seen as a tenet of their model. They seek to act as bridge builders and systems navigators in the community, and they have a deep commitment to helping people establish meaningful activity and natural supports in their life. They have small case loads and are not bogged down by paperwork, meaningless assessment, or other things that become prohibitive in getting field work done. They are patient and consistent, not rushing the service relationship, and yet are strategic with their work, efficient with their time, and focused since their intervention time is limited.

Key Program Components of the MEAM approach in Cambridgeshire include the following:

- The intervention is to wrap already existing services around a person, not to create a new one. In the words of the program lead Tom Tallon, "Let's make the systems that already exist work before we overhaul them and create new ones because that's expensive. If we can improve already existing services then that benefits everyone, not just our clients."

- Standard practice dictates that a person referred is brought together with everyone who is serving them across disciplines and they conduct what they call a "professionals meeting." This meeting, which is completely client led, identifies the person's needs and preferences, and then each person at the meeting typically leaves with an action item. At the next meeting, each responsible party reports back on the status of their action item. It is a simple framework with powerful results.

- They have a unique operational structure. There is a group of leadership staff from key providers in the community that meets regularly to discuss their clients. This group also discusses referrals and makes decisions collectively on the referral status of an individual. A governance group within the statutory sector provides upper level guidance to the work, further enabling buy-in at the leadership level of the public service sector. The program is embedded in the city council, which is hugely advantageous as it provides direct access to valuable statutory resources such as public health evaluation and buy-in at the statutory level.

- The CEA team receives referrals from the community. The referrals are reviewed and the group decides whether or not someone meets criteria at the operations meeting, which is comprised of representatives from various community stakeholders including the police, the drug and alcohol team, and mental health and housing professionals. The CEA team categorizes their clients by "levels" based on the amount of time they spend with individuals and weights the caseloads accordingly.

- For purposes of evaluation and assessment, the following tools are used:
  1. The NDT Assessment. This assessment is completed by the service coordinator and scores the client's behavior across ten areas. This includes the level of engagement with front line services, the risk of self-harm and the extent of alcohol and drug abuse.

  2. The Warwick-Edinburgh Mental Well-Being Scale©. The WEMWBS questionnaire is completed by the client and measures fourteen aspects of their mental well-being.

  3. The Outcomes StarTM. The Outcomes StarTM homelessness questionnaire is completed jointly by the service coordinator and client to measure the client's progress toward goals such as maximizing their independence.

The main tenets of the program are on rapport-building, care coordination and systems navigation, and wrapping around already existing services to meet individuals' needs. A huge devotion of time and energy is placed on building a therapeutic relationship with the client via creative engagement opportunities, earning street credibility, and meeting the perceived needs of the client over all else. This population tends to have a deep distrust of and poor history with service providers. Many community providers have written them off and they are discriminated against. The CEA team works to disarm them with a deep commitment to their self-determination.

The CEA team members serve as bridge builders in the community. They work to elevate other professionals by bringing various systems together and creating a climate of accountability whereby each system bends a bit to meet the person's needs. The CEA team is seen as serving some of the most complex individuals in the community. Therefore, the community commits itself to supporting the work of the team. This requires each silo to be at the table, increase access, bend their rules a bit at times, and communicate well.

After the intervention, ongoing care coordination is referred out. Ongoing follow up is minimal and "as needed." The CEA
team will step up to link and coordinate when an individual requires it after they have exited their program. The average duration of intervention is 12-18 months. The team consists of four individuals. There is a team leader with a great degree of experience and expertise, an individual with legal sector expertise, an individual with domestic violence expertise, and an individual with mental health expertise. The team accesses other disciplines via the professionals meeting, operations committee, and overall model of operating as a community intervention with multiple disciplines involved. The team was still in the process of determining formal criteria for discharge. Overall metrics of success were defined as quality of life improvements, cost reduction, and stable accommodation placement.

The MEAM approach in Cambridgeshire has demonstrated cost savings of over 25% to the public sector, showing a significant fall in crime and mental health costs, with other costs remaining broadly constant. Their case studies indicate significant quality of life improvements. The full MEAM evaluations are available to the public for reference (Battrick, Edwards and Moselle) (Battrick, Crook and Edwards).

General Observations
Permanent supportive housing and the Housing First approach do not yet exist in most communities in the UK, including Cambridgeshire. Housing First is being piloted in some communities but is still viewed as a controversial approach. There are private tenancies that come with light support services, i.e. social housing. The housing stock available to the complex needs population is comprised of temporary accommodations (similar to service rich shelters, safe havens, or transitional housing in the US), social housing, or private tenancies with a Housing Benefit attached that covers rent. This housing stock is limited and affordable housing overall in Cambridge is extremely limited.

There is an expressed expectation that the public sector is responsible for providing a robust social safety net. There are legal mandates in place that require public sector intervention. The social service sector depends on public sector intervention, possibly to a fault. A movement toward localism (the shift of powers from national government to local authorities based on the Localism Act of 2011) is affecting this privatization is something that was mentioned frequently from this experience is that it takes a specific commitment to serving this population outside of the tradition of what already exists to break that cycle. Implementing a Making Every Adult Matter pilot in the US is replicable and scalable. I believe the principles of the MEAM approach, programmatic components, and the clinical framework of the CEA team in Cambridge could be successfully replicated here.

Implementing the MEAM approach in the US would require a secure funding stream, ideally at the federal level, to provide credibility and ensure accountability. Oversight and technical assistance at the national level would be helpful for overall consistency in the model. Pilots such as the CSH Social Innovation Fund initiative in the US serve as models for this.

A data driven or community-based referral system for the complex needs/chronically excluded adult population would be necessary; however, a community referral system may be more realistic in smaller urban centers than in expansive rural communities or large urban centers.

A multilayered governance structure requiring public sector involvement and cross systems partnership is a must. Involving public health and/or local government would be an innovative and creative approach that could be mandated by the funding source. The clinical framework and governance structure should adhere to that of the MEAM demonstration in Cambridgeshire. Replicating the local government involvement would be difficult in the US; however, it could also be the innovative edge needed to successfully tackle the issue.

Practice and Policy Implications
Recently, I heard a physician in my community describe our complex needs population as "urban legends." In nearly every community, a tragic "revolving door" of costly crisis services is failing to successfully serve a subset of the chronically homeless population and in smaller communities many professionals are acutely aware of who these "urban legends" are. In the UK they call them "chronically excluded adults" and this language speaks for itself. They are costly, their quality of life is poor, and they serve as a reflection of systems gaps in our communities. The most valuable implication that I gained from this experience is that it takes a specific commitment to serving this population outside of the tradition of what already exists to break that cycle. Implementing a Making Every Adult Matter pilot in the US is replicable and scalable. I believe the principles of the MEAM approach, programmatic components, and the clinical framework of the CEA team in Cambridge could be successfully replicated here.

A multilayered governance structure requiring public sector involvement and cross systems partnership is a must. Involving public health and/or local government would be an innovative and creative approach that could be mandated by the funding source. The clinical framework and governance structure should adhere to that of the MEAM demonstration in Cambridgeshire. Replicating the local government involvement would be difficult in the US; however, it could also be the innovative edge needed to successfully tackle the issue.
A cross systems partnership is commonplace in the US, but the allocated resources, professionals meeting, and other political "clout" seen in the MEAM Cambridgeshire model are rare. These are the key components necessary to successfully serve this population. A successfully replicated model would have enough commitment from the community to get each traditional system to bend their criteria or normative practices at times, wrap around care coordination with key decision makers involved, government and provider buy in, a strong multi-disciplinary team, and adequate housing options.

Other practices, models, or areas to explore based on what the UK is doing should include:

- We need to understand how they have achieved lower rates of street homelessness. Are their hostels, i.e. service-rich shelters, providing a necessary period of respite and skill building that contributes to lower rates of street homelessness? Could they serve as best practice models for our existing transitional housing, safe haven, or crisis respite programs?

- The No Second Night Out initiative serves as a model for rapid response to getting someone off the streets. This initiative and the sense of urgency it encourages communities to demonstrate around an episode of homelessness provide an invaluable example of our need to shift away from a deep cultural acceptance of homelessness as a normative public health issue.

- Just as individuals in the UK may need to rely less on the public sector, we need to rely more heavily on it in the US. Our public health departments need to play a more significant role in addressing homelessness as a public health issue. Involving city council or local county health entities and integrating them or even embedding programs into them, as MEAM Cambridgeshire has done, serves as a model for directly involving public officials in the process.

- Every community needs a publicly funded broad spectrum of treatment options for substance abuse. The homeless assistance sector needs to better crosswalk harm reduction and moving people along the stages of change into housing. Coordinated assessment is going to increase the level of complex issues related to getting people with substance abuse into housing, and PSH providers will struggle with risk mitigation in the absence of fully resourced substance abuse options in their community.

- Communities in the UK employ what they call a Joint Strategic Needs Assessments (JSNA) to analyze the health needs of the population to inform and guide commissioning of health, well-being, and social care services within local authorities. The JSNA in Cambridge was part of what identified the need for the CEA team. The main goal of a JSNA is to accurately assess the health needs of a local population in order to improve the physical and mental health and well-being of individuals and communities. This needs assessment model may be a good one for us to explore in communities here.

- In Cambridge, the police play a significant role in the wrap around care of individuals. There is a "Street Life Officer" team that solely targets those who are actively demonstrating anti-social behavior on the streets. They are involved in the care coordination meetings of the CEA team. Their model of police collaboration and involvement is a good one and may be replicable in some ways, particularly outside of large urban centers in the US.

**References**


**About Aubrey Patiño**

Aubrey works for Avalon Housing - Ann Arbor, MI.
Deanna Villanueva
No Second Night Out
Host: St Mungo’s Broadway
Location: London

Photograph © Paolo Margari
No Second Night Out (NSNO) started as a pilot program in April 2011: it was the mayor’s response to rough sleeping, or street homelessness, in London. The program is built on the belief that rough sleeping is urgent, harmful, dangerous, and unacceptable. NSNO therefore seeks to get to people quickly, and ideally on the first night they are out on the street. The goals are to bring people to safety and to prevent and end homelessness, especially to prevent long-term episodes of homelessness, through quick intervention. In order to do this, outreach teams refer persons who fall into the category of new rough sleepers to one of three assessment hubs throughout London. Once in, the staff work to get the person linked to suitable accommodation, or appropriate housing, based on each person’s needs and eligibility. When it was first created, the goal was that by the end of 2012, no one would live on the streets and anyone new to the streets would not spend a second night out. As a result, once someone goes into an assessment hub, the staff work toward a 72-hour target to get that person moved on to another accommodation.

NSNO is innovative and aggressive. Its multifold approach to ending rough sleeping not only includes outreach teams that work to identify new rough sleepers, but also its efforts to engage the political community in taking responsibility for ending rough sleeping. Upper and middle management staff attend meetings with representatives from local authorities in the boroughs to engage them in sharing the responsibility of ending rough sleeping. Under some circumstances, local authorities may actually have an obligation, or a legal responsibility, to house their residents if they are experiencing homelessness. On the other hand, the US may have a responsibility to shelter but not a legal obligation to house anyone. In the UK, there are resources that make this possible, including what are referred to as social housing and the Housing Benefit. These are similar to the US’ public housing and Housing Choice Voucher programs respectively, but local authorities do not have the same wait lists for these services that ours do.

### Learning Objectives

Based on what I was able to research prior to participating in the Transatlantic Practice Exchange, I outlined what I intended to learn during my experience with the program. Since the Department of Housing and Urban Development (HUD) is moving toward increased coordination of service providers within continuums of care, I was particularly interested in learning about how NSNO coordinates services among the outreach teams, their own assessment hubs, the local authorities, and housing providers. Since communication is an integral part of an effective and coordinated service system, I also wanted to learn about how information is communicated with partners and the community. Another unique aspect of the program is the encouragement of the community to report persons who are seen rough sleeping, so I was interested in investigating the methods used to gain political and community involvement and support for ending rough sleeping. Our City of Alexandria, Virginia continuum of care at the time of my application was also looking to improve processes and procedures for measuring outcomes, an activity that NSNO does very well. I sought to discover what they

#### No Second Night Out

No Second Night Out (NSNO) started as a pilot program in April 2011: it was the mayor’s response to rough sleeping, or street homelessness, in London. The program is built on the belief that rough sleeping is urgent, harmful, dangerous, and unacceptable. NSNO therefore seeks to get to people quickly, and ideally on the first night they are out on the street. The goals are to bring people to safety and to prevent and end homelessness, especially to prevent long-term episodes of homelessness, through quick intervention. In order to do this, outreach teams refer persons who fall into the category of new rough sleepers to one of three assessment hubs throughout London. Once in, the staff work to get the person linked to suitable accommodation, or appropriate housing, based on each person’s needs and eligibility. When it was first created, the goal was that by the end of 2012, no one would live on the streets and anyone new to the streets would not spend a second night out. As a result, once someone goes into an assessment hub, the staff work toward a 72-hour target to get that person moved on to another accommodation.

NSNO is innovative and aggressive. Its multifold approach to ending rough sleeping not only includes outreach teams that work to identify new rough sleepers, but also its efforts to engage the political community in taking responsibility for ending rough sleeping. Upper and middle management staff attend meetings with representatives from local authorities in the boroughs to engage them in sharing the responsibility of ending rough sleeping. Under some circumstances, local authorities may actually have an obligation, or a legal responsibility, to house their residents. The leadership team also meets with the Mayor to provide a status update on the issue as well as NSNO progress and outcomes. By going to meetings with the boroughs’ local authorities and reporting progress and outcomes to the Mayor of London, NSNO’s comprehensive strategy strives to put rough sleeping at the forefront of social issues. NSNO also seeks to involve the public in the process of ending rough sleeping. Street Link, for instance, is a hotline that members of the public can call to notify the outreach team of someone sleeping rough. The outreach team then goes to the location where the person was seen to engage them in services.

St Mungo’s Broadway, the agency that operates No Second Night Out, recently released an annual report entitled Street to Home Annual Report that provides data from April 2013 – March 2014. During that time frame, there were 6,508 people who were seen sleeping rough by outreach workers in London. Of those, 4,363 people (67 percent of the total) were seen sleeping rough for the first time. These numbers provide a clear indication of the need for a program like NSNO.

#### Homelessness in the US and Rough Sleeping in the UK

The terminology used to describe homelessness is very different in the United States of America (US) and the United Kingdom (UK). The US uses terms like literally homeless, at-risk of homelessness, and chronic homelessness while the UK uses terms like rough sleeping and homelessness. It is important to note that the term homelessness has a much broader application in the UK than in the US and results from a lack of a standard definition of homelessness. As a result, it is more difficult for agencies in the UK to compare rates of homelessness and other factors across the country.

London is made up the City of London and 32 boroughs and has a population of approximately 8.3 million people. Each borough has what is called a local authority. The local authority operates similarly to a city government, with its own policies and procedures for addressing homelessness. One responsibility that remains the same, however, is that under certain circumstances local authorities have a legal obligation to house their residents if they are experiencing homelessness. On the other hand, the US may have a responsibility to shelter but not a legal obligation to house anyone. In the UK, there are resources that make this possible, including what are referred to as social housing and the Housing Benefit. These are similar to the US’ public housing and Housing Choice Voucher programs respectively, but local authorities do not have the same wait lists for these services that ours do.
measure, who is responsible for data entry and reporting, and what program they use and its capabilities for reporting.

**Learning**

NSNO started in London, and since its inception in 2011 the program has spread throughout the rest of England as a best practice for ending rough sleeping. I researched the original No Second Night Out program in London, which was part of an agency called Broadway that merged in April 2014 with a larger nonprofit called St Mungo’s. Now called St Mungo’s Broadway, the agency operates across London and the south of England, and has many programs and a large staff. Its London NSNO program has more than 60 staff members. The headquarters for NSNO London is located in one of the wealthiest areas of London, the City of London. This area is also known as the business sector, with very tall beautiful glass buildings and many fast-walking business people in suits flooding the sidewalks.

**Overview of No Second Night Out Program Components**

NSNO operates under the beliefs that rough sleeping is urgent, harmful, dangerous and unacceptable. As such, the program is set up to regularly identify people who are new to the street, get them to safety as quickly as possible, and then help them move on to the most appropriate housing opportunity based on needs and eligibility. In order to do this, the program has created three assessment hubs throughout London – one in the North (Islington), one in the South (Lewisham), and one in the West (Hammersmith and Fulham) – that each function as an assessment center and very temporary shelter. The physical layout of the hubs is consistent with the philosophy that rough sleeping is urgent. The hubs do not have beds. Not having beds means there is no opportunity to get comfortable and there is added motivation to move to housing quickly. Clients sleep on mats and the arrangement closely resembles that of a typical winter shelter program here in the US in which there are many people sleeping in a common room on the floor. The hubs are operated 24 hours per day, 7 days per week, and staff are constantly working to move clients on as quickly as possible.

The pathway into one of the hubs is through the street outreach teams. There are outreach teams that operate in each borough and work to connect persons who are sleeping rough to resources. Since NSNO focuses on assisting those who are new to the streets, new rough sleepers, the outreach teams use one definition to determine eligibility for the program. NSNO defines new rough sleepers as those people who have not been contacted by outreach workers previously and have not been entered into the database. Once outreach staff make the determination that the person is eligible for NSNO, they will make a referral via phone to the hub that is associated with their borough.

One unique feature of this model is its effort to engage the public in addressing homelessness. StreetLink is a nationwide, government-funded hotline that members of the public can call to inform staff of someone they have seen sleeping outside. The StreetLink team can then send outreach staff to the location where the person was seen in order to engage them in services.

Once someone has been identified as a new rough sleeper and has agreed to engage in NSNO services, outreach staff are generally able to transport clients to the hubs in order to ensure that the client gets there quickly. NSNO staff typically conduct the intake within the first hour, although they do take the condition the person is in when they arrive to the hub into account in order to determine if it might be necessary to postpone the assessment. The first step of the intake process is to welcome the new client through introductions and an explanation of NSNO. During this time, staff also do a risk assessment. The purpose of the risk assessment is to gather and assess information about each person in order to manage the possibility of incidents occurring throughout each person’s stay. Next, staff provide a tour and explain necessary operational and functional information about the hub as well as expectations and local neighborhood policies.

As part of the intake assessment, staff are looking for basic demographic information, housing history, and any support needs. The last two are critically important when determining what benefits, including housing, the person might be entitled to. After staff have gathered the information, the next step is to verify it through documentation. Staff submit requests for documentation through local agencies to verify information such as employment status, criminal history, current and past benefits, and housing history so that they can establish a local connection and make what is referred to as a Single Service Offer (SSO).

These are two very important components of the NSNO model – establishing local connections and determining Single Service Offers. Establishing a local connection is similar to establishing residency within the US; in NSNO’s case the local connection plays an important role in determining what services a client might be entitled to and where they must go to receive them. For instance, in order to access some services through the borough’s local authority, the client has to provide proof of a local connection to that borough. Once the information received during intake is verified through
documentation and the local connection is established, staff consider eligibility for benefits, including housing, to make a SSO.

Establishing a Local Connection

In order to figure out if and in which borough a client is entitled to benefits, staff collect his or her housing history and substantiate it with documentation. To determine someone’s local connection, the client’s housing history has to satisfy one of the two following requirements:

1. Resided in the same London borough for 6 months out of the last 12 months
2. Resided in the same London borough for 3 years out of the last 5 years.

Residence can be determined through tenancy (holding a lease), living with family or friends that can provide written verification, meaningful employment (work in the borough) or meaningful familial relationships (family lives in the borough).

There are generally 3 possible results:

1. The housing history reveals a local connection to a London borough.
2. The housing history reveals a local connection outside London, but in the UK.
3. The housing history reveals a local connection outside the UK.

Based on the local connection and if the connection is to a London borough, then staff also consider support needs, vulnerability, and priority. Staff then determine the SSO and present it to the client.

Single Service Offer

NSNO practices a Single Service Offer (SSO) approach.

An SSO is a credible and realistic option of accommodation tailored to an individual’s support needs and eligibility. During intake, staff assess a person’s eligibility for programs. Based on that assessment, staff provide one offer for accommodation that the client can accept or deny. Regardless of the person’s decision, that SSO will stay with that person unless their eligibility changes. SSOs can include the following options:

1. Long Term Accommodation. Long term accommodation can include what is referred to in the UK as housing in the private rented sector, which in the US is commonly referred to as permanent housing. It can also include supported housing for people who have support needs such as a current or previous history of substance use. From April 2014 to June 2014, the majority of people who were moved into a type of long term accommodation were moved to the private rented sector.

2. Temporary Accommodation. Temporary accommodation includes placement in hostels, bed and breakfasts, and detox. From April 2014 to June 2014, the majority of people who utilized a temporary accommodation were placed in hostels.

3. Reconnection to Home Area. Reconnections to home areas occur when someone’s residence is outside of London. From April 2014 to June 2014, NSNO received 481 people into their 3 hubs and of those, 254 (53 percent) were booked into long term or temporary accommodation and 130 (27 percent) were reconnected to their home area.

Staff note the SSO in a database used throughout London called the Combined Homelessness and Information Network (CHAIN). For the purposes of the outreach teams, this database captures information related to programs the person is in or has been in and also records any SSOs that have been offered.

Outreach staff are able to access this database remotely so that when they are out on the street working with rough sleepers they can access any information that might have
been captured through CHAIN. If staff find that an SSO has
been made, they will make the same offer unless the person
discloses new information that may change the person’s
eligibility for other options.

If the local connection is established in a London borough,
staff work with the local authority to determine which benefits
the client is entitled to and if the local authority has a legal
obligation to house them. This is decided based on the
client’s level of vulnerability and priority for housing, which
is determined taking into account factors including old age,
mental illness, physical disability, history of foster care, history
of military service, and homelessness due to violence.

With this information, staff work to move clients on from the
hub to suitable accommodations that meet the needs of the
client. If a person’s local connection is determined to be
outside of London, staff sometimes accompany a person back
to their home area to ensure a successful reconnection. This
could mean that the staff ensure that person connects with
family or a program in the home area.

Data Collection and Reporting

Another critical component of the operation of NSNO is its
data collection and reporting practices.

NSNO understands the importance of using data to show
the need and the outcomes of its services, so frontline staff
collect the data and there is a department within St Mungo’s
Broadway that manages the database and produces the
reports.

As previously mentioned, the database NSNO uses is called
CHAIN, the Combined Homelessness and Information
Network. St Mungo’s Broadway regularly reports on the
outcomes of the NSNO program through quarterly and annual
reports.

Most recently, St Mungo’s Broadway released the quarterly
report for April 1, 2014 to June 30, 2014, which shows that,
during that time, there were 948 new rough sleepers who had
only spent one night out on the streets. Of that number, St
Mungo’s Broadway reports that 75 percent of those persons
new to rough sleeping were prevented from spending a
second night out on the streets. The report also contains
institutional histories, demographic information and where
people exit to from the NSNO hubs.

These outcomes are reported within the agency, to members
of the community, and to politicians. NSNO uses this data to
guide future policy decisions, to remain transparent, and to
encourage the local authorities and members of the public to
get involved in ending homelessness.

Practice and Policy Implications

One of the most important goals of this experience was
learning about the model and its applicability to ending
homelessness in the US. NSNO is innovative. Its message is
concise and its staff are willing to think outside the box. There
are two components of the program that I think are particularly
applicable to how we provide services here:

1. Quick intervention to get people to safety and prevent
   people from getting used to street living; and
2. Using the central intake as an overnight shelter.

The foundation of the program is a rapid response to people
who are new to the street. The purpose is to ensure their
safety and to connect them to alternative housing options
before living on the streets becomes a way of life. NSNO cites
research that has shown that people can become accustomed
to living on the street within a matter of weeks.

The focus on quick intervention with people who are new
to the streets helps to quickly connect people who are
experiencing homelessness for the first time to the crisis
response system, thereby shortening their episodes of
homelessness and helping to prevent chronic homelessness.
This practice ties directly into the next applicable component,
which is rethinking coordinated assessment as a limited,
overnight shelter for people experiencing homelessness. This
component seeks to get people who have not experienced an
episode of homelessness in the past off the street.

After running coordinated assessment based in an emergency
shelter in the City of Alexandria for several years and
researching NSNO, I believe that there is an opportunity to
think about combining the two models. When I was running
coordinated assessment, staff would regularly suggest the
need to have a location where clients could stay overnight in
between accessing coordinated assessment and getting a
bed.

Redesigning coordinated assessment to have a time-limited,
overnight shelter component could function as a holdover in
communities in which bed spaces are scarce and the housing
market is challenging. This would provide a safe place for
people to sleep and an opportunity for staff to engage people
quickly.

Conclusion

My experience with the No Second Night Out program has
been invaluable to my professional development and my belief that innovative and aggressive program models can end homelessness. Homelessness is a complex issue that requires many solutions and beginning the dialogue across communities, including communities "across the pond," is one of the first steps in learning about best practices. I know that the dialogue and sharing that has begun as a result of the Transatlantic Practice Exchange will foster important changes to how we as a nation address homelessness.

References

4. The quarterly and annual reports can be found on the St. Mungo’s Broadway website.
Elizabeth Eastlund
Psychologically Informed Environments

Host: Thames Reach
Location: London
The Psychologically Informed Environments (PIE) concept was first developed by Robin Johnson and Rex Haigh as a transformation of the concept of therapeutic communities. I was placed at the Waterloo Project, a shelter for people with complex needs that is a collaboration between Thames Reach and the South London and Maudsley Mental Health Trust (SLaM), with financial support from the Lambeth Council's Adult Community Services. SLaM is part of the National Health Service (NHS), providing care and treatment for people living with mental health challenges. The NHS is the UK’s publically funded healthcare system, and includes mental health benefits. The Waterloo Project began implementation of a PIE two years ago. I was interested in researching PIE since I have been implementing a trauma informed approach at a domestic violence organization, Rainbow Services in Los Angeles, California, for a number of years. Rainbow Services provides shelter and support services to victims of domestic violence. Implementation of Trauma Informed Services (TIS) began seven years ago and continues to be an ongoing learning process.

My focus was in exploring how people with complex needs are assisted in a supportive environment. The population at the Waterloo Project included adults with long histories of enduring mental illness, and early and ongoing traumatic experiences, many of whom were actively using alcohol and/or substances to cope with their experiences. The criteria for admission to the Waterloo Project included being excluded from other shelters at least three times. The Waterloo Project has a high tolerance for dealing with behavioral issues and developing behavioral contracts that I have rarely seen in the homeless service systems in Los Angeles. The main difference I observed in the nature of the homeless population is that the benefits system in London appears to provide a stronger safety net for those facing challenges and especially for those with complex needs. Specifically, the Lambeth area and Council are known for being progressive in their approach to homelessness and their attempts to assist those most in need.

One major difference is simply in the size of the two countries. England as a country is just over half the size of the entire state of California, with one sixth of the population of the United States. In Los Angeles, we are dealing with county and city systems, and often the provision of services are allocated based on Service Planning Areas (SPA’s). In London, the allocation of funding for homeless services is administered by the local councils, which have specific commissioners for rough sleeping services.

Describing the differences in the systems is challenging due to the large number of homeless people in Los Angeles County. Also, the complex nature of the relationship between Los Angeles County and the City of Los Angeles creates challenges in effectively addressing homeless issues, especially for those with complex needs whom are involved with multiple systems – the Departments of Mental Health, Public Health Services, Public Social Services, Homeless Service Organizations, and typically also the justice system. In addition, families experiencing homelessness may also be involved with the Children's Protective Services.

There were some similarities in the system or what the US refers to as the Continuum of Care. London had hostel beds (similar to emergency shelter), housing similar to transitional housing (up to two years, sometimes three), and move-on housing with floating support (similar to permanent supportive housing). A key difference in the permanent supportive housing model in London is that it is not typically project based. People moving on from a shelter or transitional program rent their own housing, and continue to receive support through their Key Workers. Key Workers are similar to Case Managers in the US system. Key workers will continue to visit a person who has moved from a supportive shelter to ensure their success in living independently. There also exists a Housing Benefit for the working poor. A difference, between the system in Lambeth and the US system, is that there were very limited hostel beds as the pathway to get people into a more transitional shelter was about 40 days. While there were time limits on most of the transitional shelters, the management at each shelter appeared very flexible in working with residents who needed to stay longer. There were also lateral moves among shelters within Lambeth, which supported those persons with ongoing challenges and complex needs. The lateral moves are similar to the practice of some domestic violence emergency shelters in moving residents who may require longer stays than the typical 90 day shelter limit.

Language and staff roles

Working in a domestic violence organization, we have residential workers who oversee the shelter operations and support service staff, including case managers and counselors, who provide direct services to participants. While there is an effort to separate the roles of residential and services staff, our residential workers have the most interaction with our residents and often end up providing a great deal of supportive service on a daily basis. In London there appears to be a mix of the residential and support services positions in the Key Workers who are running the operations of the shelter and providing the needed support to the residents. Services are provided on site. At the management level, there is more distinction between the operations manager, employed by Thames Reach, and the psychologists, who are employed by SLaM. The Key workers at the Waterloo project were
encouraged to participate in activities with residents outside of the shelter. Going to see a movie or taking the resident for tea were common practices to improve the social skills of the resident.

This is very different from the practice of many social service systems in the US where we place a high value on boundaries between the worker and the resident. I found the practice of engaging residents to improve their social interactions outside of the shelter to be beneficial to the residents, who were often socially isolated due to their complex needs. Often a majority of their interactions are with various types of service providers.

I was interested in examining the significant relationship or differences between Psychologically Informed Environments (PIE) and Trauma Informed Services (TIS), specifically:

- What are the aspects of training and supervision that are beneficial to shelter staff and result in improved outcomes for survivors?
- How are staff trained and supported in their daily work with residents?
- How can we improve our services to engage survivors with multiple challenges and long histories of complex trauma?
- Is there value in incorporating aspects of PIE and TIS models to serve homeless survivors of domestic violence?

**Host Placement**

While I was placed at the Waterloo Project, I had the opportunity to visit other shelters run by Thames Reach as well as visit shelters and meet with administrators from St Mungo's Broadway. All shelters were at various stages of implementing PIE.

Thames Reach is "a London based charity helping homeless and vulnerable people find decent homes, build supportive relationships and lead fulfilling lives." Their vision is to end street homelessness. The shelters I had the opportunity to visit included the Waterloo Project, Graham House, and Lambeth High Street. Thames Reach operates a number of shelters with varying levels of support for the residents.

The Waterloo Project began integration of PIE over two years ago. The collaboration was created between SLaM and Thames Reach to bring in clinical psychologists to work with the most severe cases of enduring mental illness in a high tolerance shelter. The Project has 19 beds, 13 for men and six for women. The implementation of the PIE model included direct and indirect interventions, intentionally blending shelter operations management and a psychologist approach to management to support staff in increasing their understanding of the psychological experience of the shelter residents. The psychologists work with the residents in providing individual and group therapies, and also support the staff of the Waterloo Project and other Thames Reach shelters through providing reflective practice on a weekly basis. The Psychological Framework of the Waterloo Project includes a blend of Enabling Environments (EE), Mentalization-Based Treatment (MBT) Psychodynamic approaches, and Cognitive Behavioral Therapy (CBT).

Graham House is a more traditional transitional shelter with 69 rooms and two emergency hostel beds. While many of the shelters I had the opportunity to visit were much smaller, Graham House was the first shelter that reminded me of projects similar to those in downtown Los Angeles' Skid Row. Graham House is currently in the beginning stages of implementing a PIE approach. Management and staff are undergoing training and staff attends the reflective practice sessions at the Waterloo Project when they are available to do so.

Lambeth High Street provides shelter and housing specifically for people with diagnosed mental illness. The shelter includes eight "hostel" beds with common spaces and sixteen studio apartments in which residents typically stay for about two years. Those that leave Lambeth High tend to move on with "floating support" in which key workers continue to provide services and support while residents reside in their own apartments or flats. The manager of Lambeth High Street has a background in psychology and implements impromptu reflective practice sessions with her staff during weekly meetings.

**St Mungo's Broadway** offices and shelters I had the opportunity to visit included Griffin House, which is the main administrative headquarters for the organization, Chrysalis Project, and the Lambeth Assessment Center. St Mungo's Broadway is one of the largest organizations focused on addressing homeless issues in London and South England. St Mungo's Broadway has been instrumental in developing the Psychologically informed services for homeless people Good Practice Guide, which was released in 2012. They have been implementing psychological therapy services for their residents most in need for six years, recognizing the benefit of incorporating therapists into the support team at various shelters. St Mungo's Broadway also recognizes the need for systems level change and incorporating elements of PIE not only at the shelters, but also at the management level and throughout the work they do in the community with the various systems they interact with.

Griffin House is one of the main administrative offices in London, providing oversight to the largest provider of
homeless services. The management staff of St Mungo’s participates in a reflective practice on a monthly basis, including the directors of the various shelters where PIEs are implemented.

Chrysalis Project is an 18-bed shelter specifically for women. The shelter includes 2 units for rough sleepers, 14 transitional units, and 2 studio apartments for those preparing to move to independent living or “move on” housing. The Chrysalis Project has implemented a reflective practice for their key workers and currently has two psychologists, on a part time basis, who work directly with the residents.

Lambeth Assessment Center provides the assessment and temporary shelter for rough sleepers as they wait to be assigned to a longer-term program. Rough sleepers are often identified by outreach teams and referred to the Assessment Center.

Lambeth Council is known for being “progressive” in their approach to homelessness and originally provided the financial support to implement the PIE model at the Waterloo Project. I attended a Pathways Meeting of service providers from various organizations in the Lambeth Council area. I was able to meet with Claire Ritchie, the Commissioner for Rough Sleeping for the Lambeth Council, who initially approved the funding for the implementation of PIE at the Waterloo Project.

Commissioner Claire Ritchie described Psychologically Informed Environments by explaining that “services offering advice and support, especially to vulnerable people, or those in a stressful situation, should be designed and delivered in a manner that is sensitive to their emotional and psychological needs. Known in the homeless field as PIE or Psychologically Informed Environments, core elements of this approach include: creating a welcoming environment, reflective practice, and a theoretical framework.” The shelters I visited and the administrators and leaders I was able to speak with had various ways of approaching the implementation of PIE. The most referenced document was the Psychologically informed services for homeless people Good Practice Guide February 2012, which describes five key practice areas:

1. Developing a psychological framework
2. The physical environment and social spaces
3. Staff training and support
4. Managing relationships
5. Evaluation of outcomes

Learning

Both PIE and TIS seek to improve the way systems work with persons who are struggling with mental health issues, especially for people with the most enduring complex needs. TIS is focused specifically on the effects of traumatic experiences, and PIE understands that many mental health challenges are rooted in traumatic experiences. As such, both models seek to do no additional harm through the provision of services to vulnerable populations. Both models also emphasize flexibility and adaptability. While the framework from the Good Practice Guide is clear in describing PIE, the similarities between PIE and TIS are more closely related in the core elements below, as described by Claire Ritchie.

Creating a Welcoming Environment

Creating a welcoming environment is similar to TIS in utilizing basic customer service skills, including ensuring that we are open and engaging with our participants, and approaching our work with curiosity. In the US we use the exact language of “creating a welcoming environment” in a TIS culture. Additionally, PIE includes being aware of the physical environment of the shelter – light open spaces, quiet spaces for reflection and rest, helpful signs, etc. The Waterloo Project has developed a flexible, creative, and personalized approach to supporting their residents. The initial funding for the Waterloo Project’s implementation of PIE included renovation of the shelter to improve the space to create a more welcoming environment.

Reflective Practice

Reflective practice provides an opportunity to support staff in understanding how the work they do may be affecting them. This involves taking time to ensure staff is supported in understanding what may be happening with an individual and sharing ways to approach the individual. The Reflective Practice meetings at the Waterloo Project were facilitated by the Lead Psychologist, with managers, assistant managers, and key workers in attendance. One of the key workers would present on a particularly challenging case by describing various aspects of the resident’s life, including: what is the client struggling with most; age; gender; how long he or she has been in the hostel; history of homelessness; current difficulties and stressors; childhood history; teenage and adult life experiences; and understanding and developing a plan. Each staff member would be able to provide additional information and the psychologist provides information on the psychological processes that may be happening with the particular client. The session ends with looking at the various approaches and interventions that are working with a particular resident and developing additional solutions. The psychologists additionally prepare a summary of each reflective practice session that includes a psychological
understanding of the resident as well as guidelines for working with the resident. The additional summary assists the staff in providing a consistent approach to addressing behaviors that may be challenging. Consistency is very much an integral part of both PIE and TIS systems.

A Therapeutic Framework

The PIE model recognizes the importance of staff having a basic understanding of the therapeutic framework being used to design services and how the framework is connected to the overall program goals. The therapeutic framework at the Waterloo Project was a blend of therapeutic frameworks, including: Enabling Environment, Mentalization-Based Treatment (MBT), psychodynamic approaches, and Cognitive Behavioral Therapy (CBT). St Mungo’s Broadway has adopted the recovery model as their theoretical approach to services. For TIS the main framework is based in trauma theory. Several of the practitioners I had the opportunity to meet were familiar with the work of Judith Herman, Trauma & Recovery. Another US trauma specialist, Stephanie Covingston, had recently provided training in London on her model of Beyond Trauma, an evidenced-based group intervention for those recovering from traumatic experiences.

Additionally, when looking at the wider context of implementing and supporting PIE in homeless shelters, I found similarities with TIS in the challenge of changing organizational culture.

Organizational change process. Change is challenging. We all learn differently and some people embrace it while others may be resistant to change. There was a wide variety of reactions from key workers in the PIE model that were similar to what we have experienced in implementing TIS at Rainbow Services: some staff completely embraced the model; some understand the need to change and also need more information; and some question why there is a need to change at all.

Recognition that front line staff needs more support. While transitioning to TIS, it became evident that the residential workers at Rainbow Services often had the least amount of training and support through supervision, even though they have the most contact with our residents. There was a similar acknowledgement in the PIE model. Reflective Practice assists staff in sharing challenges and developing solutions as a group. The intent is that we learn together and address what is working well in addition to the challenges. It also provides an opportunity for staff to gain a deeper understanding of what may be happening with a particular individual and/or family based on their history and challenges.

Recognition that all aspects of an organization need training & support. Both PIE and TIS models recognize the need for all levels of an organization to have an understanding of the model. We have also learned that taking the time to provide information to staff regarding the process of change is important. The PIE model addresses this through the implementation of reflective practice and the support of psychologists in the shelter. The main difference between PIE and TIS is that in a well established trauma informed culture, the staff are supported in recognizing how their own trauma histories may affect their ability to work effectively with participants and that they may have their own “trauma triggers.” In the TIS a culture of wellness is often discussed, including defining and recognizing the signs of burnout, countertransference, and vicarious trauma. While the reflective practice aspect of PIE encourages staff to have some reflection of their own experience, I feel that creating a culture of wellness goes beyond the reflective practice session and must be adopted by the organization as a whole. It is an investment in staff that ultimately has positive effects in our work with clients.

Practice and Policy Implications

One of the main challenges of bringing a PIE system to, and even in attempting to implement TIS in, homeless systems is that most traditional homeless service organizations do not have paid therapists on staff. The main components of PIE include having an understanding of residents’ psychological processes. In the TIS model, the process of developing an understanding of how our work affects our own psyche, and therefore impacts our relationships with the participants we are serving, is best facilitated by a supervisor with clinical training.

In the US, our focus is on educational and occupational achievement, and not necessarily on recovery. This mentality is challenging when working with vulnerable populations. At Rainbow Services, we have always employed a number of Family Counselors to provide individual and group support to our residents. In addition, I can see utilizing our Family Counselors to also support the staff in their process of understanding the challenging work they do to support our families, sharing best practices, and developing additional strategies and solutions. I have already begun to implement a Reflective Practice and more formal implementation of our therapeutic model with our residential and direct service staff. My vision includes having Family Counselors assigned to provide Reflective Practice with our residential staff on a regular basis. Currently, I will be providing the facilitation of the Reflective Practice meetings every other month, while our Clinical Services Coordinator provides training on some aspect of TIS the other months.
The intention of investing in staff training and supervision and in providing support and information is to decrease staff frustration overall in their work, and to ultimately have improved outcomes with residents. Having a basic understanding of the effects of trauma assists staff in understanding that trauma triggers are "normal reactions to abnormal experiences." Ensuring homeless service organizations have a basic understanding of trauma through regular staff training and proper supervision can improve the effectiveness of staff and decrease staff burnout and turnover.

Property managers and people who work for housing programs that support people who have formerly experienced homelessness, need support and training as well. In the US, it is recommended that property management/operations of housing programs are separate from the services provided to residents. This recommendation neglects to acknowledge that the property management workers often have the most interaction with the very residents who are dealing with complex issues.

Increased collaboration among the various public and private systems and organizations that have the most contact with people with complex needs should continue to be a focus of all US policy related to addressing homelessness.

References
1. Williamson, Emma. Personal Interview. 7 May 2014
3. Ritchie, Claire. Personal interview. 14 May 2014

Recommended reading

About Elizabeth Eastlund
Elizabeth works for Rainbow Services - Los Angeles, CA.
Megan Gibbard
Youth Homelessness: Nightstops and Reconnect

Host: Depaul UK
Location: London
I spent two weeks in London in May 2014 to examine two programs that utilize family reunification and immediate one-night intervention to prevent youth and young adult homelessness in local areas. My goal was to learn how and whether these strategies could be utilized in the United States (US) to prevent and end youth and young adult (YYA) homelessness.

Transatlantic Practice Exchange learning questions:

- What are promising approaches in the United Kingdom (UK) in the areas of family reunification (Reconnect program) and immediate night-one intervention (Nightstop program) for homeless youth and young adults?
- How could these interventions be applied in the US to better serve homeless young people?

Differences and Similarities: United Kingdom and United States

Before addressing the two intervention areas, it is necessary to identify the critical differences between the UK and the US in the nature of YYA homelessness. Not surprisingly, the reasons young people end up on the streets in the UK or US tend to be similar: family conflict, failures of the child welfare system, and rejection due to sexual orientation or gender identity. The assumed responsibility and resources provided by the two governments, however, are quite different. The most radical variance is the difference in how publically subsidized housing is regarded, the scope of funding each public housing system receives, and how accessible publically subsidized housing even with the Housing Benefit is challenging and few private landlords will accept a young person using this subsidy.

Other forces impacting how Housing Benefits are applied for young people include the 2009 Southwark Judgment, which obliges children’s services to provide accommodation and support to homeless 16- and 17-year-olds. The state also has a statutory duty to house 16 and 17 year olds, foster care leavers up to the age of 21 and extremely vulnerable 18 – 24 year olds. While the Housing Benefit is the most dramatic dissimilarity between the UK and US, in addition:

- **London has effectively addressed youth homelessness.** Youth and young adults experience homelessness in most US cities and the issue is seen as an immutable and intractable social issue – something that will always be with us. In London as recently as the 1990s there was the presence of young people sleeping rough (sleeping in places not meant for human habitation). "From Oxford Street to parliament there were kids in every doorway." Today, there is a significant decrease in the number of young people sleeping rough. These youth typically “refuse” housing and services – usually due to drug or alcohol dependence. Due to the dedication of funding and housing resources, youth homelessness for 16 and 17 year olds has been nearly ended in London and the UK.
- **Families are engaged.** At every point of the various “pathways” throughout the UK – what we call a "homeless continuum of care" in the US – staff identify strategies to connect with families. The Greenwich Pathway conducts an assessment for every YYA who presents in need of housing and the YYA is asked for consent to speak with their parent or guardian. If the youth does not consent, staff first ensures abuse is not present. Finding none, they explain that although the initial contact is with the young person the staff will always work with the family.
- **"Independence" is defined differently for young people.** In the US, "independence" often means a young adult living in the private rental market – not needing any subsidy or assistance from service providers. What the UK calls “independence” is often a youth in their own apartment without staff support, but with publically subsidized rent for potentially a long period of time.
- **Education and employment supports are tied to housing.** In both countries, education and employment support happen concurrently with efforts to secure safe housing. In the UK, however, agencies like Depaul are focused on supporting young people around employment once they are housed – housing is an assumed necessity for success in employment. Conversely, in the US the path to housing might be through employment because there are no other options readily available.
- **Strong emphasis on agency coordination.** While there are rich examples of collaboration and coordination in both the US and the UK, there are...
several sophisticated examples in the UK. One example is the Camden Pathway Manager, the single point of accountability for every young person (about 200) in the London Borough of Camden. The Pathway Manager convenes weekly multi-agency meetings to review the progress of each young person.

Similarities between the two countries include the following:

- **The US and UK have similar concerns around increasing need.** The UK has seen a 300% increase in the volume of food bank usage over the past three years and an increase in rough sleeping, particularly in Cumberland, a large rural area in northwest England.

- **Neither country has an assessment tool that specifically refers young people to the appropriate type of housing.** Ultimately, the referral and acceptance to housing is made by professional judgment in both countries.

- **There are similar developments in the US and UK in the approach to service provision.** Evident across the sector is a movement from compassionate care to compassionate and strategic care, such as the use of therapeutic approaches like Psychologically Informed Environments in the UK.

- **We have similar challenges in coordinating entry to housing.** Young people in the UK must apply to the "Gateway" prior to accessing the housing pathway. Providers have concerns that the Gateway presents a barrier for youth and there is tension concerning accessing data from these coordinated systems. Leaders at the national and system levels argue strongly that coordinated entry is vital to ensure all young people go through the same process of statutory assessment and prevention activity with their families.

### Host Agency: Depaul UK

Depaul UK helps young people who are homeless and disadvantaged throughout the UK through a variety of interventions such as supported accommodation (what the US might call transitional housing), floating support (what the US might call case management), employment and training, family mediation, and Nightstops. In 2012, Depaul worked with over 3,000 young people across the UK.

A leader in the UK-wide response to YYA homelessness, Depaul was a tremendous host and instructor as I looked at two of their programs with promise for leverage in the states: Nightstop and Reconnect.

### Learning - Promising Approach: Nightstop

A 17 year old young person in London who is facing homelessness tonight walks into a drop-in center or perhaps tells a teacher, and then that drop-in center or teacher calls Nightstop. Depaul’s Nightstop staff answer between 10 am and 5 pm, do a risk assessment over the telephone, and then speak with two references. They confirm with their available hosts – there are approximately 45 trained volunteers in London – that the young person can stay in the volunteer’s spare room that night. The young person receives directions to the host’s home, knocks on the door, and is offered a meal, a room, and connection with a community member.

During the day, the youth works with the referring agency to secure longer-term safe housing. Each night until they are housed, Nightstop places them with a volunteer in the community – a different volunteer each evening or with one volunteer for several weeks on "Extended Nightstop." Nationally, the average young person will spend eight evenings with Nightstop before securing more permanent accommodation.

The volunteer specifies what nights they are available to host and is offered £15 per night for incidentals, although most hosts do not accept the fee. The young person is safely off the streets and interacts with community volunteers who care about them.

### Nightstop Program Structure

A total of four staff manage Nightstop across the UK. Nightstops are essentially franchises or chapters, with each local authority applying the scheme (a “scheme” is what we would call a program in the States) a little differently. Depaul completes the local accreditation, allowing them to use the name "Nightstop," and each location is assessed annually. Depaul also hosts an annual conference for the local affiliates.

### What type of young person is a good fit for Nightstop? Who is not well served by Nightstop?

Nightstop accepts 16 - 25 year olds who need emergency accommodation. There are not blanket bans on any “type” of young person; however, young people without a possible place to stay after Nightstop (such as asylum seekers without recourse to public funds) are typically not accepted. Nightstop works to understand any criminal record in context;
for instance a youth might have “arson” on their record for setting a postbox or wheelie bin on fire when they were 13. In this situation, Nightstop would call the potential host to talk through the situation with them.

Very high need young people are not well served by Nightstop, such as youth who may be struggling with active mental health or drug misuse issues. Staff say, “We aren’t placing kids who are really struggling with addiction, but we’re preventing kids from getting to that point.

Young people can’t believe that people are volunteering to host them. And then another person. And then another. Kids really respond to that.” Consistency is important and a reason why the program does not serve high needs young people. For example, a skilled volunteer may feel comfortable accepting a higher needs young person on Monday and Tuesday, but during the rest of the week there would not be a volunteer available. Nightstop avoids this situation and these young people are referred to other community programs as available.

As issues emerge, Nightstop responds to ensure the program remains responsive to young people. In 2013, approximately one-third of Nightstop guests in London were Muslim, but there were no Muslim hosts. A tailored strategy was launched to recruit Muslim hosts. Gay, lesbian, and transgender youth are an emerging population served by Nightstop.

How are hosts recruited? What support is provided to Nightstop host volunteers?

The Depaul staff team stressed that supporting hosts is a critical priority. Many safeguards are in place to ensure hosts (and young people) remain safe; young people are only in the host’s home when the host is present, hosts are not allowed to consume alcohol while volunteering, and youth hear the host’s “house rules” from the Nightstop staff over the phone prior to being placed. Clarity of expectations and roles is critical.

Nightstop hosts are instructed not to attempt to address the young person’s more complex needs, but to instead connect the young person back to the referring agency for support. Support while a young person is staying with Nightstop includes referral to family mediation.

Hosts are typically recruited by word of mouth – current hosts sharing the scheme with their faith community and workplace. Potential hosts are typically nervous until they meet another person who is currently involved and can ask questions. Vivian, a veteran Nightstop host, jokes, “They ask you things like ‘What do you feed them?’ and ‘What do you talk about?’ It’s like an alien turned up! Just treat them like any other person in your home!”

Nightstop Program Challenges

Nightstop is not without challenges. Insurance is an issue for hosts, as homeowner’s insurance will not cover damage or theft by the young person because they are considered invited guests. Nightstop has seen some insurance companies increase rates or deny coverage due to participation in the program. Hosts sign a waiver to hold DePaul harmless and Nightstop covers up to £100 of loss each year, though these issues are rare.

Collecting better program-level data is an emerging priority area of focus for DePaul. Nightstop collects outputs: numbers of bed nights, YYA served, and referrals made. There are still many unknown outcomes such as how many young people return to homelessness after participating in the Nightstop program.

In my week of connecting with Nightstop hosts and staff, I encountered many examples of the program being used flexibly to meet the challenging needs of young people, including:

- One young man is not safe to be around when he has been drinking heavily. Nightstop staff responds by requiring him to check in at the office prior to going to the host’s house: if he is sober then he is cleared for a room.

- Another young man is behaving very unpredictably as he moves from host to host, until a volunteer offers to keep him on Extended Nightstop. The issues stop almost immediately and the volunteer and young man have a strong and positive connection that continues today.

Learning - Promising Approach: Reconnect

DePaul’s Reconnect program is a cadre of services supporting young people’s connection with their families. Some Reconnect programs are positioned within a pathway as a ‘gateway’ to housing, while others serve as a resource when a young person requests them; they including the following.

- Reconnect Enfield: Family mediation with 16 and 17 year olds in the London Borough of Enfield as part of the local authority’s housing pathway.

- Isis Young Adult Prison: Family mediation with 18 – 25 year olds incarcerated at Isis, the young adult prison.
• No Second Night Out: Family support for any young person under the age of 25 who arrives at No Second Night Out, a London-wide service that locates and houses individuals found rough sleeping.

All three approaches are flexible, youth-driven and aim for seemingly unlikely results: the young person in crisis develops a stronger positive connection with their family.

Reconnect Program Structure

Each family mediation program is completely flexible and youth-driven. Reconnect can typically work with the young person, the young person and the family, or just the family in some cases. How family is defined is likewise flexible. Family members can include the parent, girlfriend or boyfriend, a safe adult, or whomever the young person identifies as their ongoing support toward whatever reconnection goal they determine. Staff comment, “My idea of a functional family is irrelevant. What does the family want? Support from professionals is short-lived; we’re here to help the young adult have something positive in the future when we’re not around.”

Success is redefined.

No Second Night Out staff share that young adults in the program, many of them struggling with addiction or mental health issues and currently sleeping rough, rarely go home. “At this point the family broke down a long time ago but we still support the young person to take action.” Action might look like writing a letter to a parent, as well as making peace with any possible outcome. Staff also continues to work with the young person after they obtain housing to maintain a consistent presence. Isis shares a similar attitude to redefining success for young people serving time in prison. Success could mean a parent seeing their incarcerated young person on visiting day, the young person’s first Sunday dinner at home in years, or the young inmate grappling and making peace with the fact they have no salvageable relationship with their parents.

It might not be called ”family mediation.”

“What is causing you to seek reconnection with your family now?” is the first question Reconnect asks a homeless youth who is seeking reconnection with their family, and ”mediation” is a word rarely used. Youth may have had mediation in the past that did not go well so setting a different approach is critical. The youth doesn’t believe things could be different. That first encounter is about hearing the youth’s story and about gently and persistently challenging it.

Reconnect Program Challenges

There is an inherent tension when family reconnection is associated in any way with housing. The ”reconnection” step in the pathway becomes another gateway to housing access for youth: viewed as a hoop to jump through. Youth are focused on securing housing and do not yet believe in mediation.

Tensions are likewise inherent between local authorities, who are safeguarding housing resources by trying to connect the youth back home, and Reconnect, which understands that it might take a bit longer to repair a family connection. Add family members to this calculus of mediation and housing resources and it becomes more complex. Families feel pressure around mediation; the young person might hold the balance of power in the family due to violent or chaotic behavior or there might be financial implications for the parents related to their subsidized housing if the young person leaves.

Finally, as with Nightstop, measuring outcomes and successes is an emerging area for Reconnect and for the field. There is no national database tracking homelessness across the UK so it is not possible at this time to determine if a young person’s homelessness was prevented via mediation one year later or track returns to homelessness.

Staff comment, ”Ultimately, the measure is that a young person and family feel that they have a stronger relationship.”

Practice and Policy Implications

In order to move forward, we must challenge the following deeply held assumptions about our existing homeless YYA system in the US:

• We are simply not able to intervene immediately.
• The scale of a system ensuring no young person spends a second night out is out of our reach.
• There will always be young people who sleep on our streets.

We must alter these assumptions if we are to successfully implement and bring to scale the Nightstop scheme in communities across the United States as the best practice for sheltering youth and young adults in crisis. We must take a whole systems approach nationally and locally. We must ”simply not accept sleeping rough as an option for young people.”

If we are to successfully implement the system-wide approach
demonstrated in the Reconnect programs – we must likewise alter long-held beliefs in the YYA field around families.

It is not popular to acknowledge that the approach of too many YYA systems, often urban continuums or programs, has been one of deep provider connection with young people at the expense of providing support to connect to a family member. We must integrate family reunification, ensuring it is safe but not assuming it will not be, as a priority at every step of our continuum.

Do these changes reflect cultural differences between the UK and US? Certainly the historical ethos of each country leads to different approaches in social welfare and to what we believe to be possible in terms of social change.

YYA homelessness on the streets of London was visible, pervasive, and entrenched as recently as the 1990’s. Leaders across the UK offered the following factors to explain the change that is evident on the streets of London today:

- An absolutely deliverable plan used to lobby local government.
  1. Here are the people on the streets.
  2. Here are the solutions and the cost.

- A government that held the voluntary sector and themselves accountable.
  1. A massive investment to break the logjam of the formerly intractable youth homelessness issue.
  2. Government attention down to the person. In 1999, UK’s “homelessness czar” Louise Casey is said to have received phone calls from advocates and providers in the streets: “Michael so-and-so is on the streets tonight – what are you going to do about it?” We cannot solve a problem we cannot see, and we must see each individual with a name who is struggling on our streets tonight.

We are willing to change the way we do things to better care for young people.

We are willing to move forward without all the answers, learning step by step.

We are willing to take risks for some of the most marginalized in our society – the young people experiencing homelessness across the United States.

References


About Megan Gibbard

Megan works for King County Committee to End Homelessness – Seattle, WA.
About Homeless Link

Homeless Link is the national membership charity for organisations working directly with people who become homeless in England. With over 500 members, we work to make services for homeless people better and campaign for policy change that will help end homelessness.

homeless.org.uk

About the National Alliance to End Homelessness

The National Alliance to End Homelessness is a non-profit, nonpartisan organization committed to preventing and ending homelessness in the United States. The Alliance works collaboratively with the public, private, and nonprofit sectors to build state and local capacity, leading to stronger programs and policies that help communities achieve their goal of ending homelessness. The Alliance provides data and research to policymakers in order to inform policy debates and educate the public and opinion leaders nationwide.

endhomelessness.org